## DEPARTMENT OF HEALTH AND HUMAN SERVICES

## CENTERS FOR MEDICARE & MEDICAID SERVICES

		AKE/MEDICAL TO BE COMPI							VCGU ty ID: 00208
MEDICARE/MEDICAID PROVII     NO.(L1)		3. NAME AND ADDRESS OF FACILITY (L3) GRAND AVENUE REST HOME (L4) 3956 GRAND AVENUE SOUTH (L5) MINNEAPOLIS, MN			(L6) <b>55409</b>		1. Initial 2. 1 3. Termination 4. 0 5. Validation 6. 0		7 (L8)  Recertification  CHOW  Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	UPPLIER CATEGO	ORY 09 ESRD	10 (L7) 13 PTIP	22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		. Other plaint
6. DATE OF SURVEY 9/6/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	<b>2016</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAI		ATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b):  12. Total Facility Beds 13. Total Certified Beds  14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF  (L37) (L38)	20 (L18) 20 (L17) DWN 19 SNF 20 (L39)	Compliance1. A B. Not in Comp Requirements  ICF  (L42)	unce With equirements e Based On: cceptable POC diance with Program and/or Applied Wa	n aivers:	2. Techn	nical Personnel our RN / RN (Rural SN Gafety Code A,8 HEETS	7. Me	ope of Services dical Director ient Room Size	•
16. STATE SURVEY AGENCY REM Facility's request for contin	IARKS (IF APPLICA Juing waivers in	ABLE SHOW LTC CA IVOIVING tag 04	ANCELLATION D. 58 (Bedrooms	ATE): s measu	ire at least 70	) sq ft) has	been appro	ved.	
17. SURVEYOR SIGNATURE  Carrie Euerle, HFE NE	II	Date :	0/20/2016	a 10) K	18. STATE SURV				Date: e 9/20/2016
PA	RT II - TO BE	COMPLETED I	BY HCFA REC	(L19)					(L20)
19. DETERMINATION OF ELIGIBI  _X	LITY Participate	20. COM	IPLIANCE WITH		21. 1. Sta 2. Ov	atement of Finan	ncial Solvency (HO	CFA-2572)	A-1513)
22. ORIGINAL DATE  OF PARTICIPATION  03/31/1974	23. LTC AGREEN BEGINNING		4. LTC AGREEMI ENDING DATI		26. TERMINAT  VOLUNTARY  01-Merger, Closu		05	(L30)  IVOLUNTAR'  5-Fail to Meet I	<u>Y</u> Health/Safety
(L24) 25. LTC EXTENSION DATE: (L27)	•	VE SANCTIONS n of Admissions:	(L44) (L45)		02-Dissatisfaction 03-Risk of Involur 04-Other Reason f	ntary Termination	n <u>O'</u> 07	5-Fail to Meet A THER 7-Provider Stat )-Active	
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS				
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	I OF APPROVAL I	DATE					

(L33)

DETERMINATION APPROVAL

06/24/2016

(L32)



#### 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.

Kumalu Fiske Downing

Sincerely,

An equal opportunity employer.

Grand Avenue Rest Home September 20, 2016 Page 2

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fav: (651) 215 6

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

Grand Avenue Rest Home September 20, 2016 Page 2

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

Kamala Fish Downing

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

Grand Avenue Rest Home September 20, 2016 Page 3

		POST-0	CERTIFIC	CATION RI	EVISIT F	REPORT		
	ER / SUPPLIER / CLIA		NSTRUCTION				DATE (	OF REVISIT
24E150	ICATION NUMBER	A. Building B. Wing					<sub>Y2</sub> 9/6/20	16 <sub>Y3</sub>
NAME O	F FACILITY			STRE	ET ADDRESS, (	CITY, STATE, ZIP CO	DE L	
GRAND	AVENUE REST HO	ME			GRAND AVENUE			
				MINNI	EAPOLIS, MN 5	5409		
program correcte provision	ort is completed by a n, to show those deficed and the date such n number and the ide ey report form).	ciencies previousl corrective action	y reported on th was accomplish	ie CMS-2567, State ned. Each deficien	ement of Deficion cy should be fu	iencies and Plan of ully identified using	Correction, tha either the regul	t have been ation or LSC
ITE	M	DATE	ITEM		DATE	ITEM		DATE
Y4	ļ	Y5	Y4		Y5	Y4		Y5
ID Prefix	F0465	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	483.70(h)	Completed	Reg. #		Completed	Reg. #		Completed
LSC		09/06/2016	LSC		_	LSC		-
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC		_	LSC		-
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
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LSC			LSC		-	LSC		-
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC		-	LSC		-
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC		-	LSC		-
REVIEW		/IEWED BY	DATE	SIGNATURE OF	SURVEYOR	l	DATE	

FOLLOWUP TO SURVEY COMPLETED ON

REVIEWED BY CMS RO

7/1/2016

GD/kfd

**REVIEWED BY** 

(INITIALS)

TITLE

9/20/2016

DATE

33560

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

DATE

9/6/2016

☐ YES ☐ NO

PRINTED: 10/03/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		24E150	B. WING _		C <b>07/01/2016</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409	07/01/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 000	INITIAL COMMENT	TS .	F 00	0		
F 465 SS=F	to investigate case following deficiencie enrolled in ePOC at required at the botto CMS-2567 form. EPOC will be used at 483.70(h) SAFE/FUNCTIONAE ENVIRON	ndard survey was conducted #HE150007. As a result, the es are issued. The facility is nd therefore a signature is not om of the first page of the lectronic submission of the s verification of compliance.  AL/SANITARY/COMFORTABL  Devide a safe, functional, ortable environment for the public.	F 46	55	8/31/16	
	by: Based on observate review, the facility fasanitary environment room, smoke room, facility failed to ensure residents (R1) review of odors.  Findings include: On 6/7/16, at 10:10 observations were reliable of the dining room was located above was covered in dustable. A thick layer under the heat register.			Submission of this response and P Correction is not a legal admission deficiency exists or that this statem deficiency was correctly cited, and inot to be construed as an admissio fault by the facility, the Administrato any employees, agents, or other individuals who draft or may be disc in this Response and Plan of Correlln addition, preparation and submist this Plan of Correction does not cor an admission or agreement of any I the facility of the truth of any fasts a or the correctness of any conclusion forth in the allegations.  Accordingly, the facility has prepare Plan of Correction prior to the resol of the dispute resolution process. The plan of Correction must be filed because the submission of the dispute resolution process.	that a ent of s also n of r or  cussed ction. sion of nstitute kind by alleged ns set ed this ution The	
ADODATOD	/ DIDECTOR'S OR BROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	IATLIDE	TITLE	(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

07/20/2016

**Electronically Signed** 

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		24E150	B. WING		C <b>07/01/2016</b>	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0170172010	
		_		3956 GRAND AVENUE SOUTH		
GRAND	AVENUE REST HOME			MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLÉTION	
F 465	Continued From page 1		F 465	5		
	and a live spider ar underneath the win	nd spider web were on the floor dow sill.		of the requirements under state a federal law that mandate submiss Plan of Correction within ten (10)	sion of a	
	was a large, thick, o	ading to the second level there cobweb hanging down from the smaller cobwebs.		the delivery of the CMS-2567 alle of deficiencies as a condition to participate in the program even if facility disputes any of the information.	a the	
	and covering the up and dust were pres The fluorescent ligh	surface dust on the woodwork oright scale, and layers of dirt ent along the baseboards. In the room was full of dead ots and the two cloth chairs ins.		The facility has requested the info dispute resolution process regard cited deficiency. This Plan of Co is submitted as the facility's credit allegation of compliance.  To assure compliance with this the following plan has been put into p	ormal ing this rrection ble	
	dirt on and suspend cords hanging acro dirt were on and un the window, the wir	oke room had a thick layer of dust and d suspended from the three electrical nging across a wall. Layers of dust and on and under the heat register, on top of low, the window sill, blinds, and along the ds and smoke vent. All four walls were		We have discussed the findings very housekeeper and have discussed expectations of what "clean" is an reviewed and retrained on the clear policies. Housekeeping will clear entire facility with a new view on cand will be cleaned to the Administrandard according to the updated	vith the I the d have aning n the cleaning strators	
	-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.			checklist. This will be completed date listed. Resident R1 lives in a single room has a long history of depression. this is the amount of belongings s in the room. She has for a long ti asked to clean her own room so s	by the n and Part of he has me	
	entry was full of dea survey book kept in a layer of dust. Sur were observed thro second floors of the	illing light in the front door ad bugs and black flecks. The the front entry was covered in face dust and dirty carpets ughout both the first and e facility.		would not have to move or find ar storage location for the cluttered belongings. This was documente individual resident care plan. Acknowledging that she is not abl clean the room adequately, we have implemented some interventions are working with her to clean her	nother d in the e to uve that we	
	designee (SSD) sta	nted the housekeeper was ntaining the environment.		Half of the room has been unclutt cleaned. After lengthy discussion	ered and	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		24E150	B. WING				D 1/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
CDAND	AVENUE DECT HOM	=		39	956 GRAND AVENUE SOUTH		
GRAND	AVENUE REST HOMI	=		M	IINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(=:::::::::::::::::::::::::::::::::::::				(X5) COMPLETION DATE
F 465	During the environ 6/7/16, at 2:45 p.m confirmed the large stated she notified because she could Housekeeper (H) of dayroom stating shonce a year. In R1 was working on ge along with some of the room. Housek fell apart six month the tour.  The environmental on 6/7/16, from 3:0 confirmed the coby she informed the aso ago. While with stated, R1 finally e and they planned to this afternoon. R1 crying. The admin room, the SSD look you were told two wup. As the tour coldenied knowing ab and stated if he ha full of dead bugs in cleaned it. While in administrator verificated he cleans the An undated form to Daily Housekeepin 8 Clean dayroom a. wash ashtra	mental tour conducted on the housekeeper (H) ecobweb in the stairway, and the SSD about it last week n't reach it to remove it. confirmed the dirty carpet in the see only has time to clean it 's bedroom, R1 stated she titing rid of the broken dresser the boxes she had stacked in seeper (H) stated the dresser is ago and then abruptly ended tour continued with the SSD 10-3:20 p.m. The SSD web in the stairway and stated dministrator about it week or R1 in her room SSD sharply mptied the dresser drawers of get rid of the broken dresser became upset and started istrator entered the resident's ked at R1 and sternly stated, weeks ago to clean this place intinued the administrator out the cobweb in the stairway, do noticed the fluorescent light the day room he would have specting the smoke room the sed the dirty, dusty vent and the vent weekly.	F4	.65	the resident and after involving the for assistance and storage, housely has taken over cleaning her room of side that is uncluttered. Resident is allowed her family to assist and we making faster progress on the other of the room but will keep to the car of at least one box per week. Goin fast puts the resident at risk. Much been done and we will continue to with the resident and family to uncleate other side of the room also so housekeeping can take over cleaning ide too. At the end of the entire process, housekeeping will have to over cleaning the entire room and will be involved in cleaning. To address housekeeping through entire facility which affects all resid we have reviewed and modified the cleaning task schedules. To be about his, we have increase housekeepin hours by 15%. Each room will be thoroughly cleaned weekly. To do are enforcing the resident policies in limit the amount of belongings and the belongings can be stored so clean and behind them. We are working each resident on this. In addition, we have removed carpolleaning from the housekeeping responsibilities. The facility has carthroughout the entire facility except office, bathrooms and the dining rolleaning from the housekeeping responsibilities. The facility has carthroughout the entire facility except office, bathrooms and the dining rolleaning from the housekeeping responsible facility and spot stain clean up, but we contracting with a commercial	deeping on the R1 has are or half e plan g too sh has work utter ng that ken resident the ents, ele to do ng this, we shat where eaning peds under with et peting for the om. or we are	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
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		24E150	B. WING			07/0	01/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME	<u>:</u>		3	TREET ADDRESS, CITY, STATE, ZIP CODE 956 GRAND AVENUE SOUTH IINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	mirrors, buffet, wind tables, chairs, furnit *12 Vacuum throu downstairs, hallway  A form titled Grand Housekeeping Rou indicated: Monday 1. Thorou 103.  2. Stock 3. Clear mopping.  Tuesday 1. Thorou 2. Clear 3. Clear 4. Sweet  Wednesday 1. Thorou 2. V. 2nd floor, wipe dow walls, etc.  3. Mand hallway back to 4. C basement.  Thursday 1. Thoro 204.  2. First fitted, pillowcase). 3. Clear 3. Clear 4. Sweethall and hallway back to 4. C basement.	om and living room. Clean dows, glass, baseboards, ture, etc. ghout house, upstairs, y stairs and offices.  Avenue Residence Weekly tines last updated 2/12/09, aghly clean bedrooms 102, a linens in upstairs closet. In dining room baseboards after aghly clean bedroom 201. In privacy room. In office, ap porch (on warmer days).  Proughly clean bedroom 202. In accuum stairs going from 1st to me handrails, baseboards, accuum stairs going from 1st to me handrails, baseboards, accuum stairway from kitchen to ughly clean bedrooms 203, at floor linen exchange (flat, an front door and side door including baseboards,	F	165	cleaning service to clean all of the carpeting.  The Administrator will monitor this walk through of the entire facility with housekeeper every other week. Woreated a detailed walkthrough cheso that items are not missed during walk through. Areas of concern with noted and followed before the next through. The walkthrough checklists be filled in housekeeping.	th the e cklist the I be walk	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		24E150	B. WING				C <b>01/2016</b>
	PROVIDER OR SUPPLIER	<u> </u>		395	REET ADDRESS, CITY, STATE, ZIP CODE 6 GRAND AVENUE SOUTH NNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
F 465	2. Second fitted, pillowcase). 3. Dust wi meets ceiling throu fixtures & mini-blind sprinkler heads, m  Thoroughly cleaning dusting walls, base furniture and vacual overhead bed light glass.  A form titled Grand Housekeeping Rou 3/21/01, indicated: Duties: *Clean challegs, arms, sides & cleaned 5/16.	hly clean bedroom 101. I floor linen exchange (flat, th feather duster where wall ighout house, also lights, ds, above window ledges, oldings. Ig rooms includes: Vacuuming, boards, fixtures, pipes, pull out um, clean mirrors, pictures, s, etc.). Wipe windows, clean  Avenue Residence Monthly utines 2016, last updated irs and tables used for meals; a underneath. Date last vacuum cleaner bags (or Date last completed 5/17. ilied linen hampers. Date last of from top & bottom of dryer. if from top & bottom of dryer. if from top & bottom of dryer. I for on call systems to make erly. Dated last completed groom curtains and blinds. I for on bathroom. I fe last completed 5/21. I cords with sanitizing cleaner.	F 4	165			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG	COM	(X3) DATE SURVEY COMPLETED	
		24E150	B. WING			C / <b>01/2016</b>	
	PROVIDER OR SUPPLIER  AVENUE REST HOME	:		STREET ADDRESS, CITY, STATE, ZIP CO 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		01/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 465	Chart for Housekee 3/21/01, indicated: Duties: *Dust & sci Date last dusted 1/1 *Dust bed last dusted 5/16. *Wash all washed 2/10. *Dust alor Date last dusted un *Wash all necessary. Date la *Wash all fire retardant. Date *Seasona resident's request. *Wash all underneath). Date *Seasona resident's request. *Wash all floors. Date last wa *Wash mi unknown.  A form titled Grand Housekeeping Rou 3/21/01, indicated: Duties: *Clean winc cleaned 1/19. *Wash res wastebaskets. Dat *Clean wastebaskets. Dat *Clean wastebaskets. Dat she has a check off she completes the complete the complet	rub windowsills & casings. 13. frames & mattresses. Date doors & frames. Date last ng where ceiling & wall meet. known. curtains & shades, mend if st washed 2/24. privacy screens & spray for last washed 5/17. heat registers (also last washed 2/9. I clothing exchange per Date last done unknown. supply cupboards on all three ashed 5/16. ni blinds. Date last washed  Avenue Residence Annual tines 2016, last updated dows inside & out. Date last	F4	65			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	` ´CON	TE SURVEY MPLETED
		24E150	B. WING _			C / <b>01/2016</b>
	PROVIDER OR SUPPLIER  AVENUE REST HOME	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP C 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		70172010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 465	look at the work Holooks at the check completed.  The undated Grand Housekeeping Depeffective environmelesson the hazards air, dust, furnishing fomites. Frequent interior will aid in phicroorganisms, whazards.  The undated Grand Housekeeping Depindicated periodic in will be made by the as a joint exercise of Team.  The Grand Avenue Diningroom [sic] Prindicated 1. Vacuur light fixtures and pin woodwork-basebood 4. Wipe down all raunderneath. 5. Cle fireplace. 6. Soape basement in control The undated Grand Room Cleaning Proand or sweep room ashtrays and cans, all woodwork, base frames. 4) Dust off	o.m. SSD stated she doesn't busekeeper (H) does, she just off list to see if it has been discontinuous exercises artment Policy indicated ental sanitation is required to of exposure to contaminated s, equipment, and other cleaning of the building's hysically remove some of the hich might cause these discontinuous expections of the faculty [sic] housekeeping supervisor or with the Infection Control Residence Cleaning rocedure dated 4/21/95 m room thoroughly. 2. Dust off citures. 3. Clean all ards, window sills and frame. Indiators and vacuum an mirror and doors on to use: Assert-located in	F 46	35		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	COM	(X3) DATE SURVEY COMPLETED		
	24E150	B. WING _			C / <b>01/2016</b>		
NAME OF PROVIDER OR SUPPLIER  GRAND AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP C 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		01/2010		
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE		
Soap to use: Assert the control tower. 7)  The undated Grand Walls Procedure ind pictures, calendars, beds out of the way step stool, and start work your way down OF NAILS, AND PIC do not cut your hand sockets (be sure not assert soap (baseme)  The undated Grand Cleaning Procedure thoroughly. 2. Use vedges of stairs, land residents wil [sic] be them going up or do handrails. 5. Soap to detergent. 6. Spot ocarpet spot cleaner.  The undated Grand Carpets and Rugs P clean and attractive and bad odors.  The Procedure indic 1) Vacuum ceveryday.  a) This is traffic areas. b) Be sure or other large object	and sprinkler heads. 6) t, located in the basement at ) Sweep and vacuum floor.  Avenue Residence Cleaning licated 1) Remove all and wall plaques. Move of the wall. 2) Use ladder or at the top of the wall and a. 3) BE EXTRA CAREFUL CTURE HOOKS, so that you ds. Also avoid electrical at to get them wet!). 4) Use ent at control tower).  Avenue Residence Stairway indicated 1. Vacuum vacuum hose/edging tool on ling. 3. Be aware that a using stairway and assist wn. 4. Clean baseboards, o use: Quat Sanitizer/mild elean carpet as needed with  Avenue Residence Cleaning colicy indicated: To keep a carpet that is free if [sic] dirt leated: Daily Cleaning: arpet and rugs thoroughly important especially in heavy the to remove any paper clips	F 46	55				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION  NG	(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
		24E150	B. WING		C <b>07/01/2016</b>		
	PROVIDER OR SUPPLIER  AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP CO 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		01/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 465	spotted areas with (b) Shake remover over entire c) Wipe absorbent cloth. Steam Cleaning: M	clean white absorbent cloth. e can well and apply spot	F4	65			



#### 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: 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

Kumalu Fiske Downing

**Program Assurance Unit Health Regulation Division** 

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

				STATE FO	RM: RE	VISIT REPORT				
	ER / SUPPLIER / CATION NUMBE	R	MULTIPLE CON A. Building B. Wing	ISTRUCTION					DATE OF REV 9/6/2016	
NAME OF	FACILITY AVENUE REST	Y1 T HOME	-			STREET ADDRESS, C 3956 GRAND AVENUE MINNEAPOLIS, MN 55	S0UTH	ZIP CODE	3/3/2010	Y3
correctiv	e action was action prefix code	compli	shed. Each def	iciency should be	e fully iden	reviously reported tha tified using either the efix codes shown to t	regulation o	r LSC provision	number and t	the
ITE	M		DATE	ITEM		DATE	ITEM		DATE	E
Y4			Y5	Y4		Y5	Y4		Y5	
ID Prefix	21695		Correction	ID Prefix		Correction	ID Prefix		Corre	ction
Reg. #	MN Rule 4658.1 Subp. 4	415	Completed	Reg. #		Completed	Reg. #		Сотр	oleted
LSC			09/06/2016	LSC			LSC			
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		Corre	ction
Reg. #			Completed	Reg. #		Completed	Reg. #		Comp	oleted
LSC			_	LSC			LSC			
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		Corre	ction
Reg. #			Completed	Reg. #		Completed	Reg. #		Comp	oleted
LSC			=	LSC			LSC			
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		Corre	ction
Reg. #			Completed	Reg. #		Completed	Reg. #		Comp	oleted
LSC			_	LSC			LSC			
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		Corre	ction
Reg. #			Completed	Reg. #		Completed	Reg. #		Comp	oleted
LSC			_	LSC			LSC			
REVIEWE STATE AC		REVIE\	WED BY LS)	DATE	SIGNATU	RE OF SURVEYOR			DATE	
STATE AGENCY (INITIALS)  GD/kfd  REVIEWED BY CMS RO (INITIALS)			9/20/2016  DATE TITLE			33560		9/6/2016 DATE		
<b>FOLLOW</b> 7/1/2016	OLLOWUP TO SURVEY COMPLETED ON					CORRECTED DEFICIEN CIENCIES (CMS-2567)			YES	NO

Page 1 of 1 EVENT ID: PO0F12

Minnesota Department of Health

AND BLAN OF CORRECTION TO TRANSPORT TO THE ANTI-		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00208	B. WING		07/0	; 1/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	,	
GRAND	AVENUE REST HOME		AND AVENUE POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall with a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of the Minnesota Depa	nether a violation has been compliance with all				
	number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	rule provided at the tag ale number indicated below. In several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item aring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments non-compliance with these tawritten request is made to hin 15 days of receipt of a ent for non-compliance.				
	investigate complai the following correct facility has agreed to receipt of State lice the Minnesota Depart	gation was conducted to nt #HE150007. As a result, tion orders are issued. The o participate in the electronic nsure orders consistent with				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 07/20/16

STATE FORM 6899 PO0F11 If continuation sheet 1 of 10

TITLE

(X6) DATE

Minnesota Department of Health

AND DI AN OF CODDECTION IDENTIFICATION NI IMPED:					DATE SURVEY COMPLETED	
		00208	B. WING		07/0	) 1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
GRAND	AVENUE REST HOME	·	ND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	http://www.health.si obul.htm The State delineated on the a Department of Hea electronically. Althonecessary for State the word "corrected Then indicate in the process, under the date your orders will electronically subm Department of Hea	tate.mn.us/divs/fpc/profinfo/inferent licensing orders are stached Minnesota with orders being submitted ough no plan of correction is Statutes/Rules, please enter in the box available for text. It electronic State licensure heading completion date, the libe corrected prior to sitting to the Minnesota with the libe corrected prior to sitting to the Minnesota with the libe corrected prior to sitting to the Minnesota with the libe corrected prior to sitting to the Minnesota with the libe corrected prior to sitting to the Minnesota with the libe corrected prior to sitting to the Minnesota with the libe corrected prior to sitting to the Minnesota with the libe corrected prior to sitting to the Minnesota with the libe corrected prior to sitting the libe corrected prior the libe corrected prior to sitting the libe corrected prior the libe corrected prior to sitting the libe corrected prior to sitting the libe corrected prior the libe corrected prior to sitting the libe corrected prior th	2 000			
21695	Subp. 4. Houseke provide housekeep necessary to mainta comfortable interior ceilings, registers, f and furnishings.	Subp. 4 Plant eration, & Maintenance eping. A nursing home musting and maintenance services ain a clean, orderly, and including walls, floors, ixtures, equipment, lighting, ent is not met as evidenced	21695			8/31/16
	by: Based on observati review, the facility fa sanitary environmer room, smoke room, facility failed to ensi	on, interview and document ailed to maintain a clean and nt in the dining room, day, and hallways. In addition, the ure the room of one of one ewed was kept clean and free a.m. the following		Corrected		
	1300.740710 11010 1					

Minnesota Department of Health

STATE FORM PO0F11 If continuation sheet 2 of 10

Minnesota Department of Health

AND DUAN OF CODDECTION DENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED	
					С	
		00208	B. WING			1/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRAND	AVENUE REST HOME		ND AVENUE OLIS, MN 5:			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
21695	Continued From pa	ge 2	21695			
	was located above was covered in dustable. A thick layer under the heat registelectrical cords. As and a live spider ar underneath the wincommon the stairway least a large, thick, of the ceiling along winderstairway least a large, and the ceiling along winderstairway least a large, thick, of the ceiling along winderstairway least a large, and the ceiling along winderstairway least a large, and the ceiling a large, and the ceiling a large, and the ceiling a large, and the ceil	ading to the second level there cobweb hanging down from th smaller cobwebs.  surface dust on the woodwork bright scale, and layers of dirt ent along the baseboards. In the room was full of dead its and the two cloth chairs				
	dirt on and suspend cords hanging acro dirt were on and un the window, the wir baseboards and sm dirty and stained.  -R1's room had an dust and dirt on the and on the headboaceiling above the bedrawers sat next to was restricted by st	nad a thick layer of dust and ded from the three electrical ss a wall. Layers of dust and der the heat register, on top of adow sill, blinds, and along the noke vent. All four walls were odor and there were layers of floor, along the baseboards and. Cobwebs hung from the ed. A broken dresser with no the bed. Mobility in the room acked boxes and belongings. illing light in the front door ad bugs and black flecks. The				
	survey book kept in a layer of dust. Sur	the front entry was covered in face dust and dirty carpets ughout both the first and				

Minnesota Department of Health

STATE FORM PO0F11 If continuation sheet 3 of 10

Minnesota Department of Health

AND DIAN OF CODDECTION IN INDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00208	B. WING	·····	07/0	C 01/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME	3956 GRA	DRESS, CITY, S AND AVENUE OLIS, MN 5		-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21695	second floors of the On 6/7/16, at 2:40 p designee (SSD) staresponsible for mai During the environm 6/7/16, at 2:45 p.m. confirmed the large stated she notified to because she could! Housekeeper (H) condayroom stating shounce a year. In R1 was working on get along with some of the room. Houseke fell apart six months the tour.  The environmental on 6/7/16, from 3:00 confirmed the cobwishe informed the action of the solution of the planned to this afternoon. R1 crying. The administroom, the SSD look you were told two wup. As the tour condenied knowing about and stated if he had full of dead bugs in cleaned it. While instated he cleans the stated he clean	e facility.  In the social service ated the housekeeper was nataining the environment.  In ental tour conducted on the housekeeper (H) cobweb in the stairway, and the SSD about it last week of treach it to remove it.  In only has time to clean it is bedroom, R1 stated she ting rid of the broken dresser the boxes she had stacked in the boxes she had stacked in the seper (H) stated the dresser is ago and then abruptly ended tour continued with the SSD of the stairway and stated diministrator about it week or R1 in her room SSD sharply inplied the dresser drawers of get rid of the broken dresser became upset and started strator entered the resident's ted at R1 and sternly stated, weeks ago to clean this place tinued the administrator out the cobweb in the stairway, if noticed the fluorescent light the day room he would have specting the smoke room the ed the dirty, dusty vent and	21695			

Minnesota Department of Health

STATE FORM PO0F11 If continuation sheet 4 of 10

Minneso	<u>ota Department of He</u>	ealth ealth				
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		00208	B. WING		07/0	) 1/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, §	STATE, ZIP CODE		
GRAND A	AVENUE REST HOME	_	ND AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21695	Continued From pa	ige 4	21695			
	*8 Člean dayroom a. wash ashtra b. wipe down to pictures, baseboard c. vacuum *11 Dust dining roo mirrors, buffet, wind tables, chairs, furnit *12 Vacuum throu downstairs, hallway A form titled Grand Housekeeping Rou indicated: Monday 1. Thorou 103. 2. Stock 3. Clear mopping.	ables, chairs, furniture, ds, etc.  om and living room. Clean dows, glass, baseboards, iture, etc. ighout house, upstairs,				
	2. Clear 3. Clear 4. Swee	n privacy room. n office. ep porch (on warmer days).				
	2. Va 2nd floor, wipe dow walls, etc.	oroughly clean bedroom 202. Vacuum stairs going from 1st to wn handrails, baseboards,				
	and hallway back to	Mop basement (Laundry room o storage rooms). Clean stairway from kitchen to				
	204.	oughly clean bedrooms 203,				
	fitted, pillowcase).	t floor linen exchange (flat, an front door and side door				

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 5 of 10 PO0F11

Minneso	<u>ita Department of He</u>	ealth earline				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SI COMPLE	
		00208	B. WING		C 07/01	/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
		3956 GRA	AND AVENUE			
	AVENUE REST HOME	MINNEAP	OLIS, MN 5	5409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
21695	Continued From pa	ige 5	21695			
	entryways/hallways handrails, pictures,	including baseboards, windows, etc.				
		nly clean bedroom 101. floor linen exchange (flat,				
	meets ceiling through	th feather duster where wall ghout house, also lights,				
	fixtures & mini-blind sprinkler heads, mo	ds, above window ledges, oldings.				
	dusting walls, base furniture and vacuu	g rooms includes: Vacuuming, boards, fixtures, pipes, pull out im, clean mirrors, pictures, s, etc.). Wipe windows, clean				
	Housekeeping Rou 3/21/01, indicated: Duties: *Clean chai legs, arms, sides & cleaned 5/16.	Avenue Residence Monthly utines 2016, last updated irs and tables used for meals; underneath. Date last				
	sooner if needed).	vacuum cleaner bags (or Date last completed 5/17. led linen hampers. Date last				
	*Clean lint Date last cleaned 5	from top & bottom of dryer. 5/19 bedspreads & blankets on				
	residents' beds. Da	ate last washed 5/20. rings on call systems to make				
	sure working prope 5/19.	erly. Dated last completed				
	Dated last washed					
	Privacy curtain. Dat	and wash 2nd floor bathroom. te last completed 5/21. cords with sanitizing cleaner.				
	Date last cleaned 5					

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 6 of 10 PO0F11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			B. WING		С	
		00208	B. WING		07/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	AVENUE REST HOME		ND AVENUE OLIS, MN 5			
0(4) ID	CLIMMA DV CTA		<u> </u>	PROVIDER'S PLAN OF CORRECTION	<b>N</b>	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21695	Continued From pa	ge 6	21695			
	Chart for Housekee 3/21/01, indicated: Duties: *Dust & sci Date last dusted 1/-	doors & frames. Date last  doors & frames. Date last  g where ceiling & wall meet. known. curtains & shades, mend if st washed 2/24. privacy screens & spray for last washed 5/17. heat registers (also last washed 2/9. I clothing exchange per Date last done unknown. supply cupboards on all three				
	Housekeeping Rou 3/21/01, indicated: Duties: *Clean wind cleaned 1/19. *Wash res wastebaskets. Dat	Avenue Residence Annual tines 2016, last updated dows inside & out. Date last sidents' bathroom & office e last washed 4/4. alls & light fixtures. Date last				
	she has a check of she completes the	o.m. Housekeeper (H) stated f list she dates and initials as cleaning tasks designated as , monthly, twice a year or				

Minnesota Department of Health

STATE FORM PO0F11 If continuation sheet 7 of 10

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING.			,
		00208	B. WING			)1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	AVENUE REST HOME		AND AVENUE POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21695	Continued From pa	age 7	21695			
	look at the work Holooks at the check of completed.  The undated Grand Housekeeping Depeffective environmelesson the hazards air, dust, furnishing fomites. Frequent interior will aid in ph	p.m. SSD stated she doesn't busekeeper (H) does, she just off list to see if it has been did Avenue Residence partment Policy indicated ental sanitation is required to of exposure to contaminated is, equipment, and other cleaning of the building's mysically remove some of the hich might cause these				
	Housekeeping Dep indicated periodic in will be made by the	d Avenue Residence partment Procedure 8) Inspections of the faculty [sic] Is housekeeping supervisor or with the Infection Control				
	Diningroom [sic] Prindicated 1. Vacuur light fixtures and piewoodwork-baseboa 4. Wipe down all raunderneath. 5. Cle	Residence Cleaning rocedure dated 4/21/95 m room thoroughly. 2. Dust off ctures. 3. Clean all ards, window sills and frame. Idiators and vacuum an mirror and doors on to use: Assert-located in oll tower.				
	Room Cleaning Pro and or sweep room ashtrays and cans, all woodwork, base frames. 4) Dust off	d Avenue Residence Day ocedure indicated 1) Vacuum, a thoroughly. 2) Empty all make sure to wash. 3) Clean boards, windowsills, and f pictures, light fixtures, . 5) Clean off all tables and				

Minnesota Department of Health

STATE FORM PO0F11 If continuation sheet 8 of 10

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7.1. 20.125.110.1			2
		00208	B. WING			1/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	AVENUE REST HOME		AND AVENUE POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21695	chairs, dust all pipe Soap to use: Assert the control tower. 7  The undated Grand Walls Procedure individuals	s and sprinkler heads. 6) rt, located in the basement at 7) Sweep and vacuum floor.  I Avenue Residence Cleaning dicated 1) Remove all and wall plaques. Move of the wall. 2) Use ladder or at the top of the wall and and and BE EXTRA CAREFUL CTURE HOOKS, so that you ds. Also avoid electrical at to get them wet!). 4) Use ment at control tower).  I Avenue Residence Stairway and indicated 1. Vacuum vacuum hose/edging tool on ding. 3. Be aware that a using stairway and assist own. 4. Clean baseboards, to use: Quat Sanitizer/mild clean carpet as needed with	21695			
	spotted areas with o	clean white absorbent cloth.				

Minnesota Department of Health

STATE FORM PO0F11 If continuation sheet 9 of 10

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
					C .
	00208	B. WING			01/2016
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRAND AVENUE REST HOME		ND AVENUE OLIS, MN 5			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
remover over entire c) Wipe absorbent cloth. Steam Cleaning: M per schedule using machine.  SUGGESTED MET administrator and of environment for cle address how to ma implement the plan areas of the reside clean and odor free	e can well and apply spot e surface. or blot clean with white  Maintenance will clean carpets our own carpet-cleaning  THOD OF CORRECTION: The or designee, could evaluate the eanliness. Develop a plan to aintain a clean environment, or and monitor to ensure all onts' environment remains	21695			

6899

Minnesota Department of Health STATE FORM

PO0F11 If continuation sheet 10 of 10



#### 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.

### Summary of findings:

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.

## Summary of the facility's reason for IDR of this tag:

The facility did not feel this tag should have been issued, because they did not agree with the findings at F225.

#### Summary of facts:

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.

#### Summary of facts.

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(I)(I) 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.

### Summary of the facility's reason for IDR of this tag:

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.

#### Summary of facts.

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.

### Summary of findings:

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.

#### Summary of the facility's reason for IDR of this tag:

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

Susanne Reuss, Unit Supervisor Licensing and Certification Program Health Regulation Division

Telephone: 651-201-3793

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

#### POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT					
IDENTIFICATION NUMBER	A. Building							
24E150 <sub>Y1</sub>	B. Wing	Y2	6/30/2016	Y3				
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE						
GRAND AVENUE REST HOME		3956 GRAND AVENUE SOUTH						
		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).

ITEI			DATE Y5	ITEM Y4			DATE Y5	ITEM Y4			DATE Y5
ID Prefix	F0164 483.10(e), 483.75	G(I)(4)	Correction	ID Prefix	F0169 483.10(	h)	Correction	ID Prefix	F0225 483.13(c)(1)(ii)-(iii),	(c)(2)	Correction
Reg. # LSC			O5/11/2016	Reg. # LSC			Completed - 05/23/2016	Reg. # LSC	- (4)		Completed 06/09/2016
ID Prefix	F0226		Correction	ID Prefix	F0280		Correction	ID Prefix	F0315		Correction
Reg.#	483.13(c)		Completed	Reg. #	483.20( (2)	d)(3), 483.10(k)	Completed	Reg. #	483.25(d)		Completed
LSC			06/09/2016	LSC			06/10/2016	LSC			06/09/2016
ID Prefix	F0323		Correction	ID Prefix	F0354		Correction	ID Prefix	F0356		Correction
Reg.#	483.25(h)		Completed	Reg. #	483.30(	b)	Completed	Reg.#	483.30(e)		Completed
LSC			06/09/2016	LSC			05/16/2016	LSC			04/18/2016
ID Prefix	F0431		Correction	ID Prefix	F0520		Correction	ID Prefix			Correction
Reg. #	483.60(b), (d), (e)		Completed	Reg. #	483.75(	0)(1)	Completed	Reg.#			Completed
LSC			06/09/2016	LSC			06/03/2016	LSC			
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC				LSC			_	LSC			
STATE AG		REVIEWE (INITIALS		DATE 08/26/2	2016	SIGNATURE OF S		18623		06/30	)/2016
REVIEWE CMS RO	D BY	REVIEWE (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				в 🔲 по					

PRINTED: 08/26/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	24E150	B. WING			C 1 <b>8/2016</b>
NAME OF PROVIDER OR SUPPLIER  GRAND AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409	<u> </u>	10/2010
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL : IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
been found guilty of a mistreating residents had a finding entered registry concerning at of residents or misappe and report any knowled court of law against an indicate unfitness for sother facility staff to the or licensing authorities.  The facility must ensure involving mistreatment including injuries of undicately to the additional of the other officials in acceptance of the stablished postate survey and certifications are thorough prevent further potent investigation is in progressentative and to with State law (includicertification agency) wincident, and if the allegation is misappropriation.	employ individuals who have abusing, neglecting, or by a court of law; or have into the State nurse aide buse, neglect, mistreatment propriation of their property; edge it has of actions by a an employee, which would service as a nurse aide or ne State nurse aide registry is.  The state all alleged violations in the state is an accordance with state is all alleged gold in the state is an accordance while the gress.  The state nurse aide registry is an accordance with State is a state in accordance with	F 2	25		6/9/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Electronically Signed 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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
			A. BUILDI	NG		С
		24E150	B. WING			18/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
004440		_		3956 GRAND AVENUE SOUTH		
GRAND	AVENUE REST HOM	E		MINNEAPOLIS, MN 55409		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE PROPRIATE	COMPLÉTION DATE
F 225	Continued From page	age 1	F 2	25		
		NT is not met as evidenced	1 2	20		
	by:	ivi is not met as evidenced				
		tion, interview and document		Submission of this response a	and Plan of	
		failed to report allegations of		Correction is not a legal admis		
		ies of unknown origin, neglect		deficiency exists or that this st		
	of supervision for e	elopement and substance		deficiency was correctly cited,		
		cility for 5 of 17 residents		not to be construed as an adm		
	(R20, R7, R16, R1	4, R6).		fault by the facility, the Adminis		
	Cinalina a in alcoda			any employees, agents, or oth		
	Findings include:			individuals who draft or may be in this Response and Plan of C		
	R20 was admitted	to the facility on 3/23/15. A		In addition, preparation and su		
		(MDS) annual assessment		this Plan of Correction does no		
		ified R20 as independent with		an admission or agreement of		
		ving and intact cognition.		the facility of the truth of any fa		
	,			or the correctness of any cond		
		Safety Assessment dated		forth in the allegations. Accord		
		20 had an extensive history of		facility has prepared this Plan		
		poor decision making, and was		Correction prior to resolution of		
		treatment three times per		dispute resolution which must		
		ment further indicated "since ed illegal drugs." The		because of the requirements used and federal law that mandates		
		r identified R20 had multiple		of a Plan of Correction within t		
		(A) issues since admission		days of the delivery of the CMS		
		pices. Staff recommendations		allegations of deficiencies as a		
		t indicated R20 could leave the		to participate in the programs.		
	facility independen			of Correction is submitted as t		
				credible allegation of complian	ce.	
		3/15, in R20's medical record		_		
		inistrator revealed that R20		To assure compliance with this		
		alcohol in her room which		following plan has been put int		
		ther resident (R7) going to the		The Administrator met with OF	-	
		The note indicated that this ne this has occurred.		management to clarify the rep criteria for Vulnerable adult rep		
	was not the mst th	ne uns nas occurred.		between federal and state req		
	R20's progress po	tes were reviewed from 1/16		Incident and investigation repo		
		nd revealed on 2/3/16, at 7:30		been submitted to OFHC for F		
		nd to be lethargic and		R20.	,, and	
		ergency Medical Services		We have updated our reporting	a policy and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG		c	
		24E150	B. WING			18/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
GRAND	AVENUE REST HOME	<u>.</u>		3956 GRAND AVENUE SOUTH			
GITAILD	AVERTOE TIEST TISME	-		MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 225	Narcan (medication overdoses such as emergency room. Floor Hospital Discharge indicated that R20 for altered mental soverdose.  R20's Mental Healt through 4/5/16, ind history of heroin ababuse" and staff hoverdose was suspsummary further in altercation with anofamily member and monitored by staff" identified a history heroin overdose arnow had and order. Interview with the son 4/14/16 at 2:42 aware of R20's her SWD was unaware hospitalizations due asked if R20's herohospitalization was The SWD replied the be reported, ever flow chart."  Interview with the in (IDON) on 4/15/16 was the nurse work was aware of R20's unaware why R20 was aware was	ed, the resident was provided in which reverses some. Heroin) and transported to the R20 was admitted. R20's Summary dated 2/8/16 was admitted to the hospital status and accidental heroin. In Summary dated 3/5/16 icated R20 had a "lengthy buse and methamphetamine and an order for Narcan if sected. The mental health dicated that R20 had a verbal other resident and resident's length and resident	F 2	workflow charts for reporting. begun retraining the staff on requirement to report these g We have modified our vulner staff in-service material to ad and address these issues. In reporting was done correctly cases, but DON and Adminis continue to monitor staff for coreporting internally.  We have also recommended OHFC in their reporting proceducumentation to include this to clarify the confusion betwee federal requirements.	the poing forward. able adult d this clarity nternal in these trator will compliance in changes to ess and information		

-	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  ND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		24E150	B. WING _			C / <b>18/2016</b>
	PROVIDER OR SUPPLIER  AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP CO 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		10/2010
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F 225	with R20 having an drug use prior to 2/3 drugs in the facility, should be reported replied "I don't known R7 was admitted to diagnoses included disorder, schizophr R7's MDS quarterly 1/5/16, indicated R3 was independent w R7's careplan dated of history of chemic The care plan identificated the care plan consumed alcohol in R7's progress notes through 4/11/16, an 9:11 p.m. R7 was founable to sit up in be was called and R7 hospital. She return got the alcohol from R17. An emergency admission sheet dath at R7 was hospital R7's medical record appointment referrational intoxication that was hidden in the An interview with the 4/14/16, at 4:03 p.m.	y similar incidents related to 3/16, was not aware of any When asked if this incident to the state agency the IDON v."  the facility on 9/30/14, with but not limited to mood enia, and alcohol dependency. The review assessment dated 7's cognition was intact and ith activities of daily living.  d 10/19/15, included VA issues all use making poor decisions. ified 12/28/16 (sic-facility as the year 2016) R7 that resulted in hospitalization. It was transported to the need 12/28/15. R7 reportedly in her roommates R20 and y department hospital atted 12/17/15, which indicated alized for alcohol intoxication.  It included a psych all dated 1/11/16, which need R7 was hospitalized for Roommate gave her alcohol	F 2	25		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		CON	(X3) DATE SURVEY COMPLETED			
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	PROVIDER OR SUPPLIER  AVENUE REST HOME	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP C 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		10/2313
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 225	The SWD stated the problem, just because if it was an ongoing problem on the care administrator confirmesulting hospitalizate agency. The assince agency. The assince agency.  An interview with the p.m. revealed she to incident to "where incident to an incident to "where incident to an incident to the incident was taken ambulance. The hoof 0.37. On 11/18/1 had been admitted R16 returned to the On 12/8/15, at 10:00	use something happens once, issue I would have put it as a eplan." The SWD and med the alcohol use and ation were not reported to the administrator stated the equired to be reported, even if nat the facility followed a flow of incidents to the state.  The SWD and median were not reported to the administrator stated the equired to be reported, even if nat the facility followed a flow of incidents to the state.  The IDON on 4/15/16, at 2:28 thought the facility reported the tashould be reported to."  and admitted to the facility mitment for chemical MDS dated 12/7/15, indicated by intact, mildly depressed, had symptoms directed towards do care daily.  The essment (CAA) dated 12/7/15, receiving anti-psychotic care daily.  The color is allowed to have (LOA's) and self administer of the emergency room via the energency room via the energency room via pspital reported an alcohol level 5, it was documented that R16 to the hospital. On 11/24/15,		25		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		COM	(X3) DATE SURVEY COMPLETED			
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F 225	medications through be back at 10:00 p. through her boyfrie facility until 12/15/1 why she didn't return had some things I had some history of alcold dependencies, treathistory of unstable getting alcohol from favors.  On 12/25/15, R16 had medications. Rather the facility to emergency room a pneumonia. The facility to emergency room a pneumonia. The facility to emergency room and extended time with for no overnights on On 4/14/16, at 2:42 administrator were LOA's. The SWD s form and ask for momplete one common self administration resident did not return the state agency, the state agency, the required to be reported to be reported to be reported to the state agency. The IDON was not	h bedtime. She stated she will m. Although contacted and, R16 did not return to the 5 at 5:30 p.m. When asked an for a week, R16 replied "I had to take care of." mary dated 12/9/15, indicated: iant with medications, had a hol use and multiple chemical tment programs and long housing. R16 was currently in her boyfriend in exchange for went on LOA with her boyfriend at 6 stated she would be back 2/26/15, at 6:45 p.m. R16 inform them she was at the ind was being admitted for cility verified this with the ER written, undated by Information identified cohol, left premises for out notice. Broke court order attack of facility." p.m. the SWD and asked for policies for resident tated the residents "Sign LOA eds." The SWD stated they munity assessment and one of medication assessment. If a curn from the outing, she would be sWD stated they were "Not rted, even if hospitalized. We	F2	25		

	FATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		COM	(X3) DATE SURVEY COMPLETED		
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F 225	IDON at 2:00 on 4/considered R16 an "I thought it was rep. The facility failed to intoxication to the Salso failed to report through 12/15/15, to facility reported it to missing person. R14 quarterly MDS intact and was inded daily living. R14's concentified her as a work of facility p. 3/20/16, R14 had be by another resident day. The noted indicated R14 had derogatory names (every day). R14 so recently as the previous further stated a resother residents and that resident up. R14 had be situation, but not the situation, but not buring a subseque 10:22 a.m., R14 stated and the situation of the si	15/16. The IDON had not elopement, but she was a VA, corted." I report R16's alcohol state agency (SA). The facility the elopement from 12/8 the elopement from 12/8 the police on 12/10/15, as a indicated she was cognitively ependent with all activities of are plan dated 2/23/16, yulnerable adult and indicated issues.  Progress notes indicated in een called a derogatory name in the facility three times that cated "this incident was very a progress note dated 4/12/16, complained of being called by another resident "qday" tated it had happened as	F 2	25		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
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GIIAND	AVENUE HEST HOME	-		MINNEAPOLIS, MN 55409		
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F 225	allegations. She staconcerns she would stated "you have to happening, or if it is happening." The Stoth the state agency stated verbal aggree not reportable to the place "frequently" be resident.  R6's quarterly MDS was cognitively intabeliefs) and was included and was included and was included and was included and state of the MDS also indice going from sitting to did not use any most became short of brindicated R6 had din hypertension, and smild mental retardad dated 4/14/15.  R6's care plan date vulnerable adult an and 2/16/16, indicated and 2/16/16, indicated issues. 12/23/15, to "Fx [fracture]. of profinger (etiology unk it happened)"  Observation on 4/1 R6 walking without into the smoking room. At 1 observed to stumblismoking room.	ated when a resident had did talk to the other person. She separate whether it's their perception of what's WD further stated, "reporting isn't always the answer." She ession between resident's is the estate agency and takes but are not an actual threat to a did dated 2/5/16, indicated R6 act with delusions (fixed false dependent with all activities of diressing and personal hygiene. Cated R6 was unsteady when to standing or turning around, bility devices and that R6 eath with walking. R6's MDS agnoses of anemia, diabetes, echizophrenia. Diagnosis of ation noted on office visit note and 8/26/15, identified R6 as a discomments dated 11/16/15, ated no vulnerable adult emporary care plan problem eximal phalanx of L [left] 5th nown-resides not know how 3/16, at 11:40 a.m. identified a cane, limping and stumbling om. R6 fell into a chair in the 12:41 p.m. R6 was again e and fall into chair in the	F 2	25		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER  AVENUE REST HOME	:		STREET ADDRESS, CITY, STATE, ZIP C 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409			
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F 225	4/21/15, at 11:29 a. hours p[after] being eye all puffy and 2 s R [right] eye. She dhappened." Type of abrasion, and swell staff did not know vresident did not ren/Accident report did or state agency well was a swelle and two small lacer long around eye." "fell against."  Note dated 4/21/15 [complaining of] (ur States hit head on to help guide her." 4/21/15 through 4/2 administrator or SA unknown origin.  Nurses Record and 12/23/15, at 1:30 p. office and showed noted bruising on the minor swelling. R6  Physician' Progress indicated R6 was in bruising and swellir not remember hittir note indicated X-ra	m. indicated "Pt woke up-few up we noticed her R [right] sm [small] lacerations around oes not remember how it injury listed as "hematoma, ing." Incident form indicated when injury happened and nember falling. Incident I not indicate the administrator re informed of the injury.  I Progress Notes dated m. indicated: "Appears pt something during the nocen right eye under each eye rations are 3 mm [millimeters] Does not remember what she door going to BR-has flashlight Review of progress notes are 1.7/15, did not indicate the were notified of the injury of I Progress Notes dated m. indicated R6 came into nurse her left hand. Nurse he front and back of hand with was sent to urgent care.  S Notes dated 12/23/15, a clinic for assessment of any phand or banging it. Progress y showed fracture of proximal finger splint placed and	F 2:	25			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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GRAND	AVENUE REST HOME	<u> </u>		3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409			
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F 225	Continued From particular orthopedic follow up recommended.  The Serious Injury the Office of the Orthopedic follow up recommended.  The Serious Injury the Office of the Orthopedic final or the Office of the Orthopedic final or	Report dated 12/23/15, sent to mbudsman for Mental Health ation, indicated R6 had are of the fifth finger of the left of how the injury happened does not know what observed swelling and bruising ection triggering others to be nedical, OHFC [Office of Health - State agency] and adult nk.  A R6 was unable to state what he Office of the Ombudsman was no evidence that the state of the significant injury of the significant injury of the ombudsman's office agency because they were not sues.  A 4/15/16, at 9:25 a.m. licensed N)-A said "We do not the administrator. If there is a notify administrator on the because we have dealt with it. admitted to the hospital we	F 2	DEFICIENCY)	PROPRIATE		
	SWD said "I don't t the administrator be	4/15/16, at 9:27 a.m. the hink they would bother calling ecause it was not a vulnerable a serious injury. [Administrator]					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
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F 225	vulnerable adult iss being beaten. Do n fall."  During interview on administrator said, me. I expect them to the policy and the policy and the policy also incidents then it is reported to the policy and the policy also incidents the policy and treatment of physical, verbal, form of maltreatme of physical, verbal, form of meglect, inversible policy also incident prior to adoptentially dangerored to the policy and potentially dangerored to the policy and potentially dangerored to the policy and approximate the policy and the policy a	w about fractures if it were a ue like the fracture was due to ot need to know if it is due to a 4/15/16, at 2:15 p.m. the "I ask them to chart notifying to notify me about fractures."  4/15/16, at 2:19 p.m. the cility reported injuries of porting fractures depended on know where the resident had aid, "If there have not been any not reportable. We report to supposed to." When asked ries of unknown origin to the sthe office of the ombudsman ave always reported to the entitled "Vulnerable Adult ention Plan" dated 3/6/15, acility "does not tolerate any nt" which included "any form mental or sexual abuse; any oluntary seclusion, corporal nandling of resident property".	F2	25		

	IONI NILIMDED.	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
241	E <b>150</b> B. WING		C <b>04/18/2016</b>
NAME OF PROVIDER OR SUPPLIER  GRAND AVENUE REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409	04/10/2010
(X4) ID SUMMARY STATEMENT OF DEFIC PREFIX (EACH DEFICIENCY MUST BE PRECEI TAG REGULATORY OR LSC IDENTIFYING IN	DED BY FULL PREF		BE COMPLÉTION
F 225 Continued From page 11 flowchart to determine the reportir requirements"Nursing completes the internal rewhish [sic] is a collection of inform needs to be submitted to MDH on Administrator submits the online Minnesota Department of Health is available" -"You must make your report direct Administrator immediately after ersafety. The facility is responsible reportable incidents and suspecte MDH."  F 226 SS=E ABUSE/NEGLECT, ETC POLICIE  The facility must develop and imple policies and procedures that prohim instreatment, neglect, and abuse and misappropriation of resident policy for reporting of allegations of injuries of unknown origin, neglect of elopement, substance abuse wifor 5 of 17 residents (R20, R7, R1)  Findings include:  The facility's policy entitled "Vulner Maltreatment Prevention Plan" daindicated that the facility "does not form of maltreatment" which include	eporting forms nation that line. The eport to the mmediately as city to the facility nsuring resident to report all d crimes to  ES  Ilement written libit of residents property.  as evidenced and document onalize their of verbal abuse, to of supervision lithin the facility 6, R14, R6).  rable Adult ted 3/6/15, tolerate any	Submission of this response and F Correction is not a legal admission deficiency exists or that this statem deficiency was correctly cited, and not to be construed as an admission fault by the facility, the Administrator any employees, agents, or other individuals who draft or may be disc in this Response and Plan of Corre In addition, preparation and submist this Plan of Correction does not cor an admission or agreement of any the facility of the truth of any fasts a	that a ent of is also n of r or  cussed ction. sion of nstitute kind by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		SURVEY PLETED
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form of neglect, involunishment or mise. The policy also incilied. In assessment or resident prior to ad potentially dangerored. Individual susceptincluded in the overwith goals and approafety.  If maltreatment is administrator must. In administrator subministrator subministrator subministrator subministrator immediately. In a facility reportable incident. In activities of daily live. In a facility of substance making, and was continued to making, and was continued to minimus per well as a formation of the policy of substance making, and was continued to minimus per well as a formation of the policy of substance making, and was continued to minimus per well as a formation of the policy of substance making, and was continued to the policy of substance making, and was continued to the policy of substance making, and was continued to the policy of substance making, and was continued to the policy of substance making, and was continued to the policy of substance making, and was continued to the policy of substance making, and was continued to the policy of substance making, and was continued to the policy of substance making, and was continued to the policy of substance making, and was continued to the policy of substance making, and was continued to the policy of substance making, and was continued to the policy of substance making, and was continued to the policy of substance making, and was continued to the policy of substance making, and was continued to the policy of substance making and the policy of substance making an	mental or sexual abuse; any voluntary seclusion, corporal handling of resident property". luded the following: will be made of a prospective mission for a known history of the behavior patterns" tibility will be assessed and rall resident careplan along roaches for prevention and a suspected of observed the be notified immediately".	F 22	or the correctness of any conforth in the allegations. Accordacility has prepared this Pla Correction prior to resolution dispute resolution which must because of the requirements and federal law that mandate of a Plan of Correction within days of the delivery of the Clallegations of deficiencies as to participate in the program of Correction is submitted as credible allegation of compliance with the following plan has been put in The Administrator met with Commanagement to clarify the recriteria for Vulnerable adult in between federal and state refunction and investigation report workflow charts for reporting begun retraining the staff on requirement to report these we have modified our vulne staff in-service material to accommand address these issues. I reporting was done correctly cases, but DON and Administration to include this to clarify the confusion between the confusion the confusion between the confusion the confusion that the confusion the confusion the confusion that the confusion the confusion that the confusion that the confus	ordingly, the in of of any st be filed sunder state e submission in ten (10) MS-2567 is a condition is. This Plan is the facility's ance.  This the into place. OHFC eporting reports equirements. ports have R7, R16, and ing policy and g. We have the going forward. Table adult did this clarity in these strator will compliance in dichanges to cess and information of the strator will compliance in the strator will be strator	

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	PROVIDER OR SUPPLIER  AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP COE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 226	drugs". The assess had multiple vulnera admission related to recommendations of R20 could leave the A note dated 12/28/signed by the admit admitted to having contributed to anoth emergency room. The was not the first time R20's progress note 1/16-4/11/16 and re R20 was found to be Emergency Medica activated, the reside (medication which is such as Heroin) and emergency room. For Hospital Discharge indicated that R20 for altered mental soverdose.  R20's Mental Health 3/5/16-4/5/16 indicated that R20 for altered mental soverdose was susp summary further incommendation with another than the such as the support of the such as the support of the su	ment further identified R20 able adult (VA) issues since of poor choices. Staff on the assessment indicated of facility independently.  (15 in R20's medical record histrator revealed that R20 alcohol in her room which her resident (R7) going to the five note indicated that this e this has occurred.  (16 se were reviewed from evealed on 2/3/16 at 7:30 a.m. e lethargic and unresponsive. I Services (EMS) were ent was provided Narcan everses some overdoses of transported to the R20 was admitted. R20's Summary dated 2/8/16 was admitted to the hospital tatus and accidental heroin and in Summary dated ated that R20 had a "lengthy use and methamphetamine of an order for Narcan if ected. The mental health dicated that R20 had a verbal ther resident and resident's "needs to be closely R20's careplan dated 3/3/16 of heroin addiction-recent dindicated that the facility	F 2	federal requirements.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		24E150	B. WING			C <b>04/18/2016</b>
_	PROVIDER OR SUPPLIER  AVENUE REST HOME	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP C 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 226	Interview with the Son 4/14/16 at 2:42 aware of R20's her SWD was unaware hospitalizations due asked if R20's here hospitalization was The SWD replied the bear reported, every flow chart".  Interview with the lit (IDON) on 4/15/16 was the nurse work was aware of R20's unaware why R20 morning. The IDON with R20 having and drug use prior to 2/drugs in the facility should be reported replied "I don't know R7 was admitted to diagnoses that includisorder, schizophr R7's Minimum Data assessment dated was intact and was daily living.  R7's careplan dated adult (VA) issues of behavior and chemidecisions. The care facility dated the care consumed alcohol services and consumed alcohol.	Social Worker Designee (SWD) p.m. revealed that she was oin overdose on 2/3/16. The e if R20 had any other to overdose. The SWD was oin overdose with reported to the state agency. The incidents were "not required en if hospitalized. We follow a noterim Director of Nursing at 2:28 p.m. revealed that she sing on 2/3/16 and stated she is previous drug use but was was unresponsive that I stated she was not familiar y similar incidents related to 3/16 was not aware of any. When asked if this incident to the state agency the DON	F2	26		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG	) COM	TE SURVEY MPLETED
		24E150	B. WING			C / <b>18/2016</b>
	PROVIDER OR SUPPLIER  AVENUE REST HOME	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP C 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 226	through 4/11/16, and 9:11 p.m. R7 was founable to sit up in be was called and R7 hospital. She return got the alcohol from R17. An emergency admission sheet dathat R7 was hospital R7's social service reviewed and indicated worker designee (Sthe drinking inciden R7 got angry and service appointment referrational intoxication that was hidden in the An interview with the 4/14/16, at 4:03 p.m. familiar with R7's contamiliar with R7's contam	and revealed on 12/27/15, at bound with a "blank stare bed" and slurred speech. 911 was transported to the ned 12/28/15. R7 reportedly her roommates R20 and y department hospital ated 12/17/15, which indicated alized for alcohol intoxication.  progress notes were also ated on 1/4/16, the social SWD) spoke with R7 regarding at and resulting hospitalization. Creamed "that was not me."  d included a psych al dated 1/11/16, which nat R7 was hospitalized for . Roommate gave her alcohol	F2	26		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG	` ´COM	E SURVEY IPLETED
		24E150	B. WING _			C 1 <b>8/2016</b>
	PROVIDER OR SUPPLIER  AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP CO 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 226	thought the facility rit should be reported 11/9/15, under comdependency. The Mated 12/7/15, indicintact, mildly depressymptoms directed care daily. The Care Area Assindicated R16 was medications for any The undated care pmissing person repfacility at specified the leaves of absence (medications. Nursing progress nr. 16 was found to bresident was taken ambulance. The hoof 0.37. On 11/18/1 had been admitted R16 returned to the On 12/8/15, at 10:0 and spend the day medications through be back at 10:00 p. through her boyfrier facility until 12/15/1 why she didn't returned to medications through her boyfrier facility until 12/15/1 why she didn't returned to medications through her boyfrier facility until 12/15/1 why she didn't returned some things I had some thi	reported the incident to "where d to".  and admitted to the facility mitment for chemical finimum Data Set (MDS) rated R16 was cognitively seed, had verbal behavioral towards others, and rejected ressment (CAA) dated 12/7/15, receiving anti-psychotic receiving anti-psych	F 2:	26		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
				····		С
		24E150	B. WING		04	/18/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ODAND	AVENUE DEST HOME			3956 GRAND AVENUE SOUTH		
GRAND	AVENUE REST HOME	<u>:</u>		MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE  (EACH CORRECTIVE ACTION SH- CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 226	favors. On 12/25/15, R16 v and medications. R that evening. On 12 called the facility to emergency room al pneumonia. The facility for extended time v order for no overnig On 4/14/16, at 2:42 (SWD) and adminis for resident LOA's. residents "Sign LO The SWD stated th assessment and or medication assess return from the outi missing person pro When asked if the of the state agency, th required to be repo follow a flow chart." The IDON was not scheduled phone of IDON at 2:00 on 4/- considered R16 an vulnerable adult (W The facility failed to intoxication to the S report the elopeme SA even though the police on 12/10/15 R14 quarterly Minin she was cognitively	vent on LOA with her boyfriend a 16 stated she would be back a 2/26/15, at 6:45 p.m. R16 inform them she was at the and was being admitted for cility verified this with the ER of nursing (IDON) 's hand scharge/Summary Information option of alcohol, left premises without notice. Broke court and soutside of facility."  p.m. the social work designee strator were asked for policies. The SWD stated the last form and ask for meds."  ey complete one community are self administration of ment. If a resident did not ang, she would utilize the	F 2	26		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION  NG	COM	E SURVEY MPLETED
		24E150	B. WING			C / <b>18/2016</b>
	PROVIDER OR SUPPLIER  AVENUE REST HOME	:		STREET ADDRESS, CITY, STATE, ZIP 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 226	dated 2/23/16 ident and indicated no vu. A review of facility p 3/20/16, R14 had be by another resident day. The noted indicated R14 had derogatory names (every day). R14 streently as the previous further stated a resother residents and that resident up. R the situation, but not buring a subseque 10:22 a.m., R14 states house yells all the to deal with."  During an interview social work designer responsible for han abuse and abuse a resident had conceperson. She stated whether it's happen of what's happening "reporting to the stanswer." She stated resident's is not repand takes place "frethreat to a resident. R6's quarterly Minir R6's quarterly Minir	ified her as a vulnerable adult illnerable adult illnerable adult issues.  progress notes indicated in een called a derogatory name in the facility three times that cated "this incident was very a progress note dated 4/12/16 complained of being called by another resident "qday" tated it had happened as vious day.  If on 4/12/16, at 4:26 p.m., R14 ident in the house is "nasty" to stated another resident beat 14 stated the staff is aware of one did anything about it.  Int interview on 4/14/16, at ated another resident in the ime and is "bossy" and "hard on 4/15/16, at 2:15 p.m. the see (SWD) stated she was dling and reporting potential llegations. She stated when a rns she would talk to the other "you have to separate ing, or if it is their perception g." The SWD further stated, ate agency isn't always the diverbal aggression between portable to the state agency equently" but are not an actual	F 2	26		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G	COM	E SURVEY IPLETED
		24E150	B. WING			C <b>18/2016</b>
_	PROVIDER OR SUPPLIER  AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	delusions (fixed falsindependent with ald dressing and perso indicated R6 was usitting to standing of any mobility devices breath with walking diagnoses of anem schizophrenia. Diagretardation noted of 4/14/15.  R6's care plan date vulnerable adult and 2/16/16, indicasisues. 12/23/15, te "Fx [fracture]. of profinger (etiology unk it happened)"  Observation on 4/1 R6 walking without into the smoking room. At 1 observed to stumbly smoking room.  Review of Incident/4/21/15, at 11:29 a. hours p[after] being eye all puffy and 2 s R [right] eye. She dhappened." Type of abrasion, and swell staff did not know we resident did not rem/Accident report did	_	F 220			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG	` ´CON	E SURVEY MPLETED
		24E150	B. WING			C / <b>18/2016</b>
	PROVIDER OR SUPPLIER  AVENUE REST HOME	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP C 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 226	Nurses Record and 4/21/15, at 12:00 p. [patient] fell against [night], has a swolle and two small lacer long around eye." "fell against."  Note dated 4/21/15 [complaining of] (ur States hit head on to help guide her." 4/21/15 through 4/2 administrator or SA unknown origin.  Nurses Record and 12/23/15 at 1:30 p. office and showed in noted bruising on the minor swelling. R6  Physician's Progresindicated R6 is in clorusing and swellir not remember hittin note indicated X-ray phalanx of left fifth orthopedic follow up recommended.  The Serious Injury the Office of the Orand Mental Retarda sustained an fracture hand. Description of indicated "resident happened. Nurse of the Nurse of the Nurse of the Orand Mental Retarda sustained an fracture hand. Description of indicated "resident happened. Nurse of the	I Progress Notes dated m. indicated: "Appears pt something during the nocen right eye under each eye rations are 3 mm [millimeters] Does not remember what she progress not some progress notes to be a some progress notes and progress notes and progress notes are progress notes and progress notes are progress notes and progress notes are pro	F 2	26		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	PLE CONSTRUCTION  G	COM	E SURVEY PLETED
		24E150	B. WING			C <b>18/2016</b>
	PROVIDER OR SUPPLIER	:		STREET ADDRESS, CITY, STATE, ZIP CODE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409	<u>,                                    </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 226	Facility Complaints protection were bland protection were bland During interview on Licensed practical redocument notifying fracture we do not reweekend or nights of the resident were would let them known During interview on SWD said "I don't the administrator be adult issue, it was a would need to know vulnerable adult issue being beaten. Do not fall."  During interview on administrator said, me. I expect them  During interview on interim director of neacility reported injuring Reporting fractures we know where the said, "If there have is not reportable. We supposed to." Whe injuries of unknown versus the office of said, "I have always the said."	edical, OHFC [Office of Health - state agency] and adult nk.  4/15/16, at 9:25 a.m. hurse (LPN)-A said "We do not the administrator. If there is a notify administrator on the because we have dealt with it. admitted to the hospital we w."  4/15/16, at 9:27 a.m. the nink they would bother calling ecause it was not a vulnerable a serious injury. [Administrator] about fractures if it were a ue like the fracture was due to ot need to know if it is due to a a d/15/16, at 2:15 p.m. the "I ask them to chart notifying to notify me about fractures."  4/15/16, at 2:19 p.m. the urses (IDON) stated, the ries of unknown origin. depended on whether or not resident had been. The IDON not been any incidents then it the report to where ever we are an asked about reporting origin to the state agency the ombudsman the IDON is reported to the same place."				0/0/40
F 315 SS=D	483.25(d) NO CATH RESTORE BLADD	HETER, PREVENT UTI, ER	F 31	5		6/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		24E150	B. WING	<del></del>		C 18/2016	
	PROVIDER OR SUPPLIER  AVENUE REST HOME	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CO 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 315	Based on the resid assessment, the faresident who entersident who entersindwelling catheter resident's clinical or catheterization was who is incontinent attreatment and servinfections and to refunction as possible.  This REQUIREME by: Based on observative, the facility freassess, identify a provide assistance residents (R6) revidents	ent's comprehensive acility must ensure that a set the facility without an is not catheterized unless the condition demonstrates that is necessary; and a resident of bladder receives appropriate ices to prevent urinary tract estore as much normal bladder	F3	Submission of this response Correction is not a legal adm deficiency exists or that this deficiency was correctly cited not to be construed as an adfault by the facility, the Admir any employees, agents, or or individuals who draft or may in this Response and Plan of In addition, preparation and sthis Plan of Correction does an admission or agreement of the facility of the truth of any or the correctness of any corforth in the allegations.  Accordingly, the facility has performed to the facility of the requirements and federal law that mandate of a Plan of Correction within days of the delivery of the Challegations of deficiencies as to participate in the programs.	sission that a statement of d, and is also lmission of nistrator or ther be discussed f Correction. Submission of not constitute of any kind by fasts alleged nclusions set orepared this esolution of must be filed a under state e submission ten (10) MS-2567 is a condition		

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING				SURVEY PLETED
		24E150	B. WING			04/1	D 1 <b>8/2016</b>
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		.0,2010
					956 GRAND AVENUE SOUTH		
GRAND A	AVENUE REST HOME	<b>Ξ</b>			MINNEAPOLIS, MN 55409		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	V	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE
F 315	Continued From pa	age 23	F 3	15			
	•	inderclothing and placed them			of Correction is submitted as the fa	cility s	
		in her room. No staff			credible allegation of compliance.	omity o	
		ovided to R6 at that time.			Survey Team information written is		
					incorrect and we are requesting a l		
	During an interview	on 4/13/16, at 3:25 p.m. R6					
		ence had improved but that			To assure compliance with this the		
		ed incontinence if she was out			following plan has been put into pla		
	of the facility for a p	period of time.			We have interviewed R6 and she r		
	Б	14540 1004			being completely continent. R6 sa		
		on 4/15/16, at 8:21 a.m.,			urologist and had a medical proced		
		A stated she did the residents' R6's underclothes were often			completed to 5/17/16 to help R6 to decrease urgency. Our new DON		
		d, "I don't think [R6] cleans			completed a new bladder assessm		
	herself appropriate				R6. The results were that the resid		
	norsen appropriate	.y.			continent with the existing overnigh		
	During an interview	on 4/15/16, at 8:29 a.m.			toileting plan.	•	
		nurse (LPN)-A stated R6's			Actions taken to identify other pote	ntial	
		up and down" and verified R6 🚄			residents having similar occurrence		
		ce at times. LPN-A verified		1	Each resident has a bladder asses		
		roach stating, "We wake her			as part of their medical record. We		
		ting, but not during the day."			reviewed the bladder assessments		
		ad not been revised to include			other residents and have determine	ed that	
		ping R6 improve her			no changes are needed.		
	continence during t	the day, nor to R6 with personal hygiene			The quality assurance committee, including the Medical Director, revi	owod	
	following incontine				the bladder assessment form and	ewea	
	Tollowing incontine	ice.			determined that no changes are no	eded	
	During an interview	on 4/15/16, at 2:08 p.m. the			Nursing will continue to monitor	caca.	
		nursing (IDON) stated R6 had			incontinence and notify the DON w	hen	
		ver the years but stated the last			there is a change in status as well		
	several years she h	nad been incontinent mostly at			chart in the resident medical record	J. The	
		ated R6's incontinence "has			DON will continue to complete blac		
		ontrol." Therefore, her care			assessments upon admission, qua		
	•	revised to include regular			or more often as needed. The DO		
		ping R6 manage the			continue to take actions as necess		
	incontinence.				when changes in a bladder assess		
	There was a second	and a constant of the first			warranted. We have added incont		
		ent assessment which			monitoring to the weekly DON ched		
	accurately reflected	d R6's pattern for continence,	l		The Administrator will monitor to n	ıallılalll	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION (		SURVEY PLETED
		24E150	B. WING				D 18/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME			3	TREET ADDRESS, CITY, STATE, ZIP CODE 956 GRAND AVENUE SOUTH		
				IV	IINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 315 F 323 SS=E		ing and grooming assistance d.  - ACCIDENT	F 3		compliance by monitoring the weekly DON checklist.	-	6/9/16
	environment remain as is possible; and adequate supervision prevent accidents.	sure that the resident ns as free of accident hazards each resident receives on and assistance devices to  NT is not met as evidenced					
	review, the facility finterventions to prefor 4 of 4 residents for accidents.  Findings include:  R20 was admitted tannual minimum dated 2/6/16, identiactivities of daily lives R20's Community \$8/3/15, indicated R2 poor decisions, chewas currently attendives. The assessinad a history of sub "former heroin additional tas used illegal drugger accidents."	cion, interview and document ailed to supervise and provide vent injury and hospitalizations (R20, R7, R16, R6) reviewed  To the facility on 3/23/15. An ata set (MDS) assessment fied R20 as independent with ing and intact cognition.  Safety Assessment dated 20 had a history of making emical dependency issues and ding treatment three times per nent further indicated that R20 estance abuse and was a ct" and that "since admission gs". The assessment also made multiple poor choices.		5	Submission of this response and PI Correction is not a legal admission the deficiency exists or that this statemed deficiency was correctly cited, and is not to be construed as an admission fault by the facility, the Administrator any employees, agents, or other individuals who draft or may be discrimithis Response and Plan of Correction and submission of the truth of any fasts all or the correctness of any conclusion forth in the allegations.  Accordingly, the facility has prepared Plan of Corrections prior to resolution any dispute resolution which must be because of the requirements under and federal law that mandate submission and Plan of Corrections within ten (10 days of the delivery of the CMS-256)	hat a ent of s also of or or ussed ction. sion of stitute cind by lleged as set of this on of e filed state ssion of o)	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		24E150	B. WING _			C 18/2016	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
		_		3956 GRAND AVENUE SOUTH			
GRAND	AVENUE REST HOME			MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	Continued From pa	ge 25	F 32	3			
	assessment indicate independently. The plan to minimize sate of the facility. In addeveloped a plan with minimize the risk of alcohol and/or illegate. A note dated 12/28 signed by the admit admitted to having contributed to anoth emergency room. If the first time this haviolation of the facilistated that addition to ensure the safety residents and suggistic subject to random in change. R20's mediation to minimize the residents and suggistic to random in the residents.	immendations identified on the led R20 could leave the facility facility had not developed a fety risks when R20 was out dition, the facility had not lith appropriate interventions to R20 obtaining and using all drugs in the facility.  (15, in R20's medical record instrator revealed that R20 alcohol in her room which her resident (R7) going to the The note indicated this was not ad occurred and that this was a lity policy. The note further all interventions were required to of R20 and the other ested that R20 was now soom checks and a room dical record did not identify incidents related to alcohol use.		allegations of deficiencies as a to participate in the programs. of Correction is submitted as to credible allegation of compliar.  To assure compliance with this following plan has been put in saw a physician on 5/2/16 and surgeon 5/5/16. The result of was to receive cortisone shots knee to improve her gait due to osteoarthritis and will follow up months for review. R6, R7, ar specifically reviewed at the QA 5/19/16. R6 was recommended physical therapy to improve he had previous refused, but after the seriousness of this need for has now agreed to attend. R7 stable before the incident and has been discharged. R20's community assessment has and community assessment the contraction.	This Plan he facility s he for he facility he facili		
	1/1/16-4/11/16, and 2/3/16, at 7:30 a.m. although able to res Given 5 ounces of so thirsty". One halt couldn't eat breakfastomach". R20 was was called by room worried" about R20 across bed with her Res. warm and bre 80/bpm and strong responsive-pupils of	es were reviewed from revealed the following:  resident appeared lethargic spond to questions if asked. apple juice and stated "I'm just f hour later R20 states she ast and "felt sick to her checked again after the nurse mates stating they "were. Nurse found resident "laying ad and neck hyperextended. athing, pulse approx [sic]. Res. just not lilated. 911 was calledarcan (a medication to reverse		and community assessment hupdated.  Actions taken to identify other residents having similar occur have reviewed other resident of for history of addictive behavioupdated the community assess care plan interventions for each necessary.  We will continue to screen resincrease our research on issurand chemical addictions. The SWD will continue to qualify reare within the scope of a Boar home. We do screen and have	potential rences. We diagnoses or and will sments and the as idents and es of alcohole DON and esidents that d and Care		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
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GRAND AVENUE REST HOME	<u> </u>		MINNEAPOLIS, MN 55409		
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taken to ER". Physical 2/3/16, a "Postnote entry that indicated found a suicide not not reported any suduty from 7 am-3 president admitted for 2/3/15, at 5:00 p.m.  There was no follow information regarding medical record.  R20's Hospital Discindicated that R20 of for altered mental soverdose.  Review of R20's MI discharge summary 1/9/16. In addition a was completed on was completed on was completed on summary. Licensed stated "We only negative stated" when the rest."  R20's Mental Healt 3/5/16-4/5/16, indichistory of heroin ab abuse" and staff has	and resident responded and ician and family notified.  "was written below the above that "EMTS [sic] state they e and took it with them. Resulcidal thoughts to this nurse on m [sic]. EMTS [sic] state for snorting heroin".  R20 admitted to hospital who up documentation to the ng R20's suicide note in R20's charge Summary dated 2/8/16, was admitted to the hospital status and accidental heroin  DS assessments indicated any was also completed on an entry tracking record MDS 1/13/16.  The 1/9/16 hospital discharge mentation, the SWD stated a provide them with any written depractical nurse (LPN-A) ed the medication list, we	F3	accepted four potential reside past six months. We have re nursing staff on the important orthostatic pressures and hav our Fall Scene Investigation re include more details on report in orthostatic blood pressures followup required before the conthe form. We have a new DO and she will be reviewing each form for completion, correctnes followup.  The DON will implement these and the Administrator will mor maintaining compliance by reversall Scene Investigation report QA meetings.	etrained the e of the e updated eport to ing of drops and the ompletion of N in place n new fall ess and e changes ittor that we viewing the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVE COMPLETED	
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F 323	summary further in altercation with and family member and monitored by staff".  R20's careplan date of heroin addiction-indicated that the fafor possible heroin further indicated stand symptoms of dhospitalization on 2 initiation of off-site identified on the calidentified on the calidentified the reside issues this past qualidentify concerns with R20's labs were reversed to the stated positive 3/26/16. R20's mediany further follow under the stated that she did was a love letter to committed suicide. Had been given along the she and R16 contained to the she and R16 contained the she and R16 contained the she she and four had "wet herself". It knowingly used Helike her boyfriend with the S(SWD) on 4/14/16 in the she she with the S(SWD) on 4/14/16 in the she she with the S(SWD) on 4/14/16 in the she with th	dicated that R20 had a verbal other resident and resident's l'needs to be closely  ed 3/3/16, identified a history recent heroin overdose and acility now has Narcan orders overdose. The careplan aff was to monitor for signs rug overdose. R20's rug overdose. R20's replan. R20's careplan further ent had no vulnerable adult arter. The careplan did not ith alcohol possession or use. Viewed which indicated that for THC (marijuana) on dical record did not indicate p with the positive lab result.  ed on 4/14/16, at 3:15 p.m. and not write a suicide note, that it her boyfriend who had R20 also confirmed that she ohol as a gift. R20, R16 and s and when she and R16 left and "gotten into it" and whole bottle". R20 stated that cted the nurse when they also stated she had roin laced with Fentanyl, just	F 32	3		

	I TO I OIT WEDIOAITE	A MEDICAID SETTICES				IVID IVO.	0930-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 323	SWD did not know hospitalizations due stated she had follot the note that the En indicated the hospitalization as using there was no docur medical record about further stated she who stated she "water aware of R20's pashad tested positive confirmed this was careplan. The SWD or alcohol in the fact was in treatment for she attended as or had alcohol in her of the room, R7 consumptions of R20 did not have a upon her hospital regroommates". The Sallowed in the facility alcohol use in the facility alcohol use or interface use were addresse stated "I don't know can say if you don't leave. She is not condon't have any lever litterview with the Interview with the Interview with the Interview working of R20's previous don't R20's R20	if R20 had any other et to overdose. The SWD owed up with the hospital on MT's found, which she tal nurse stated was a love cide note. The SWD confirmed mentation of follow up in R20's tut the note. However the SWD discussed the incident with R20 anted to live". The SWD was at drug use and stated that R20 for marijuana once before and not indicated on R20's of stated there were no drugs cility. She further stated R20 or past drug addiction, which dered. The SWD stated R20 oom and when R20 had left umed the whole bottle. The room change as R7 stated enter that she "loved her sWD stated that alcohol is not the swD stated that alcohol is not the swD was not aware of R20's acility and when asked if ventions to prevent alcohol d on R20's care plan the SWD what you want me to do. It follow the rules you have to the swo was not aware of R20's acility and when asked if ventions to prevent alcohol d on R20's care plan the SWD what you want me to do. It follow the rules you have to the swo was not aware of R20's acility and when asked if ventions to prevent alcohol d on R20's care plan the SWD what you want me to do. It follow the rules you have to the swo was unresponsive that was aware largues. The IDON was was unresponsive that	F	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURV COMPLETED	
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F 323	morning. The IDON familiar with R20 har related to drug use was not aware of a IDON stated she did the morning of 2/3/information from th IDON stated somewith the hospital and actually a "love letter IDON stated this in followed up in R20' R7 was admitted to diagnoses that incluschizophrenia, and R7's careplan dated vulnerable adult issubehavior. Chemica The care plan identified that resulte favorable. Not a type 1/11/16 and 4/11/16 identified. R7's care appropriate interversion monitoring R7 for R7's progress note 10/21/15-4/11/16 at 12/27/15 at 9:11 p.1 a call from [R7]'s sithe phone with [R7] The nurse went to "blank stare unable speech. The nurse	I stated that she was not aving any similar incidents prior to 2/3/16. Further, she ny drugs in the facility. The d not observe a suicide note 16, and was only aware of the EMT's. The one at the facility followed up d found out the note was er" and not a suicide note. The formation should have been s medical record.  I the facility on 9/30/14, with uded mood disorder, alcohol dependency.  I d 10/19/15, included the sues of "hx of promiscuous I use making poor decisions". If if it is the year 2016) consumed d in hospitalization Prognosis of "No VA issues" were en plan did not identify nations to minimize alcohol use	F 323	3		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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F 323	Continued From particles of the continued From Particles of th	ge 30 m. 911 arrived and R7 was d walk on her own, speech e was carried down to the first s.". R7 was transported to the n. R7's family notified and ed. m. R7's roommates (R20, e and informed that R7 had Vodka that they left in the ent out to smoke. When they nce bottle of Vodka was empty. ed. m. nurse updated emergency is consumption of alcohol. m. R7 returned from the	F 3	DEFICIENCY)			
	and writer did not c 1/11/16, care confe had 1 hospitalizatio	ent continued to be agitated ontinue conversation.  rence held today. Resident n due to alcohol s given to her by her					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER  AVENUE REST HOME	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CO 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		0 17 10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	roommate. Resider incident along with past quarter.  R7's medical record appointment referration included the note that alcohol intoxication alcohol level was >  An interview with that 4/14/16 at 4:03 p.m familiar with R7's a The SWD stated shoommate had alcohol in the house. The Swere completed with The SWD confirmed of room checks and residents that were completed R7's car was addressed in Formous and problem, just once, if it was an oritias a problem on the discussed the declined treatment again and she be informed R7's room not have alcohol in to other residents.  An interview with that (IDON) on 4/15/16 aware of R7's alcohol hospitalization. How day the incident occar.	d included a mental health al dated 1/11/16, which nat R7 was hospitalized for . The not identified R7's blood 0.3.  The swide the SWD was looked and dependency issues. The was unaware R7's bhol. Alcohol was not allowed SWD stated alcohol searches the room checks once a week. The was not aware of any currently using alcohol. SWD re plan and stated alcohol use was a because something happens and stated alcohol use was the because something happens and stated alcohol use was the careplan". The SWD stated alcohol use with R7 and she R7 said she "would not do it lieves her". SWD stated she mates (R20, R17) they could the house nor provide alcohol use was not intoxication and wever she was not working the	F3	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CON	TE SURVEY MPLETED
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F 323	Rules and Respons beverages were all approval from the pwere allowed in the R16 was admitted to commitment for chefacility failed to ensupervision and into the risk for elopemental been committed initially on 8/5/14, a on 12/30/14. R16 with discharge on 3/31/material conditions R16 missed many clinic and continued contributed to multive required a full hip rehospital record ider admission at that tidischarge planning (SW)-B called and work designee (SW) Residence."  A Hennepin County Health Department Management, Case 11/10/15, identified asked to leave trea unstable blood sughistory of unstable another facility und commitment until 1 Support Plan (ICSF Hennepin County stable county stable commitment county stable commitment until 1 Support Plan (ICSF Hennepin County stable)	sibilities" included no alcoholic owed in the home unless prior ohysician and no illegal drugs	F 32	3		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 323	364 days and R16 The identified goal better. The docume complete a Rule 25 re-connect with worlook into dealing wi socialize with peers blood sugars and calso identified with did not have a diag The ICSP indicated fetal alcohol syndropregnant. R16 had other physical healt of alcohol consump Ave Residence in consoriety and to clos R16 was accepted 11/9/15, under complete dependency until 1/2. The Minimum Data indicated R16 was depressed, had verificated towards of R16 was independent and had a diabetic The undated care palcohol intoxication homelessness. The treatment three tim week, and will not conscient to schedule appointm Check resident bag Check boyfriend's kills Screening at facilitim manager involved.	longest period of sobriety was expressed interest in sobriety. was to be sober and feel ented strategies included: it, return to Huss recovery, men for sobriety, maybe AA, th mental health issues, at Grand Avenue, manage ount carbohydrates. R16 was anxiety and depression, but nosis of severe mental illness. I R16 had 2 children, both with ome, due to her drinking while sustained head injuries and the injuries related to high levels out on. R16 was placed at Grand order to help encourage sely monitor blood sugar levels, and admitted to the facility on mitment for chemical (1/16.  Set (MDS) dated 12/7/15, cognitively intact, mildly that behavioral symptoms hers, and rejected care daily, ent with activities of daily living,	F3	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 323	was attending treat therapy. Had been resulting in one hos issues included any mental health mediappointments. Resadult issues since a missing person repfacility at specified. The Social Service indicated anxiety at can made poor decorated anxiety at can made poor decorated treatmer. Nursing progress in PN11/17/15, at 6:00 room to get blood sfor glucose monitor to eat supper. Four Was very difficult to confused and did in trying to redirect to with assist of one. It placed to paramedic had any alcohol too PN 6:15 p.m. Parar resident. PN 6:30 p.m. Parar Fairview University PN 11/17/15 ETOH concentration] leve times the legal limit PN 11/18/15, contir resident here at Gradrinking vodka all contraction of the progression of the policy of the progression of the progr	mments included: Resident ment three times weekly, and intoxicated since admission spitalization. Mental Health kiety, resident was taking cations and attending ident has had no vulnerable admission, but did have one ort for failure to return to time.  Assessment dated 11/13/15, and "when intoxicated resident cisions and behaviors change." ctations were "Attend at and therapy, stay sober." otes (PN) included: p.m. writer went to resident's sugar. Did not come to office ring. Had stated was not going and resident in (R17's) bed. parouse. Resident appeared of understand writer when room-unable to sit up in bed Blood sugar level 222. Call cs, questioned resident if she lay, and denied alcohol usage. medics transporting resident to Hospital.  Intoxication [alcohol of 10.37 per nurse [more than 3].  placed call to FVR [hospital]:	F3	323			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 323	cab. Resident state PN 11/25/15 2:00 at to name, denies parent upstairs sitting areas sleep, drinking cryston R16 or Beverag open soon. Remain Physicians Progress indicated recent horintoxication-returner assessment. PN 11/27/15 at 9:30 [leave of absence] machine and Novo demonstrated to wiverbalizes understaknowledgeable aborder absence of LOA, took bus. The undated Resid signed by R16 on 121. There will be not in the home unless physician. 22. There will be not in the home. 38. We need to know times. Residents at leaving the home. I destination, contact time of return. The dining room on the 41. When planning the day, staff must planning to be absestaff requires a 24 leaving the dining room at 24 leaving the day, staff must planning to be absestaff requires a 24 leaving requires a 24 leaving the day.	ent returned from hospital via ded "thanks for taking me back".  I.m. resting sound, did awaken in. At 4:00 a.m. Awake, sitting a with roommate, stated can't stal clear. No alcohol smelled e. Instructed smoke room in calm. Cooperative.  Is Notes dated 11/25/15, spitalization due to alcohol de yesterday 11/24/15. Rule 25 a.m. Resident going on LOA with oral meds, accucheck log insulin pen. Has riter proper use of pen and anding of sliding scale. Is but her medications and has 11:50 a.m. Left with boyfriend ent Rules and Responsibilities 2/1/15, included: a alcoholic beverages allowed prior approval from the original drugs allowed in the enterprise of the property	F 32	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG	(X3) DA <sup>-</sup> COI	(X3) DATE SURVEY COMPLETED	
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F 323	required. Physicians Progres identified Ok to do discretion. Please of unit/10 gram of carl at facility. " [Consurecommendation "t grams of carbs. Ma accurately is not poop PN 12/8/15, 10:00 pthen spend day with HS [bedtime]. She 10:00 p.m. PN 12/8/15, at 11:00 from outing. PN 12/9/15, at 1:00 from outing. PN 12/9/15, at 4:30 called and said resito facility until tomo having car trouble "Mental Health Sum R16 was noncompled in the progression of	s Notes dated 12/2/15, toxicology screen at facility discontinue Novolog order [I bs], "Do not do Carb Counting Itant pharmacist he current order is 1 unit/10 king this assessment issible in the home"]. Datient left via taxi to doctor in boyfriend. She has meds till states she will be back at 0 has not returned as planned. In a.m. R16 had not returned a boyfriend.  I a.m. R16 had not returned a boyfriend.  I p.m. Residents boyfriend dent will not be coming back rrow at 1:00 p.m. "Stated"	F3	23			

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GRAND	AVENUE REST HOME	Ē		3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC  (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	No call back at 2:30 as missing person. PN 12/10/15, 5 p.m report. PN 12/11/15 7:40 p [boyfriend's] number the telephone to R1 to (Grand around 8 have a working car PN 12/11/15, called PN 10:30 a.m. reside PN 12/11/15, 9 p.m 8:00 p.m. (late entr PN 12/14/15, at 5 pto [boyfriend's] cell him to have R16 cashe is returning. PN 12/14/15, at 5:1 call from [R16], she evening at around 9 PN 12/14/15, at 8:0 writer/nurse to report tomorrow am becar Resident reports she PN 12/15/15, at 5:3 LOA-stated had "in house was able to why she did not retisome things I had the An undated handwiseason to be jolly awhen I go to [boyfri would be alright if I be back on the 26th Drinking!!! I under realize what I did w "Please" just take it would mean a lot to get the state of the sta	D p.m. writer reported resident  a. patrol officer came to make  b.m. writer, nurse called  cr, he answered and handed  6 she states she will be back  cp.m. this evening, they do  b. boyfriend's phone to contact.  dent [R16] left voice mail.  resident did not return at  y).  b.m. Writer/nurse placed a call  phone and left a voicemail for  all us back to let us know when  5 p.m. writer/nurse received a  e states she will be back this  p.m.  po p.m. Resident called  ort she will not be back until  use something came up.  the is not drinking.  to p.m. resident returned from  sulin needles" at boyfriends  give self-insulin. Writer asked  urn for a week, replied "I had	F 3	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24E150	B. WING _			C / <b>18/2016</b>	
	PROVIDER OR SUPPLIER  AVENUE REST HOME	:		STREET ADDRESS, CITY, STATE, ZIP C 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 323	she will be back Fri PN 12/25/15, at 10: [R16's] boyfriends of [R16] was sleeping PN 12/26/15, 11:00 return call at boyfrie PN 12/26/15, at 5:0 boyfriend's number on the line. PN 12/26/15, at 6:4 call from [R16], she riverside ER to get until she can have I she will she will be PN 12/26/15, 10:09 from [R16] she stat pneumonia, they ar plan to do a further PN 12/26/15, at 10: riverside ER and sproom nurse. He stat pneumonia. Physicians Progres continues to consur of crystal light. Atte session. PN 1/7/16, Resider member [aunt] cam The interim director written, undated Dis "Currently in hospit peripheral neuropatione, bladder incordiabetes type II (DND islocation. Psychia ETOH abuse, chror Consumption of alcextended time wither session of alcextended time wither session.		F 3:	23			

NAME OF PROVIDER OR SUPPLIER   GRAND AVENUE REST HOME	-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
MANE OF PROVIDER OR SUPPLIER  GRAND AVENUE REST HOME  (XA) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 323  Continued From page 39 continued therapy for chemical dependency, needs clinic involvement for management of DM II. [F16] was admitted on 11/9/15, from EVR hospital. During course of stay, resident remained non-compilant with facility rules concerning alcohol on premises and leasang facility without notification. Although compliant with medical appointment & treatment programs on course of improvement."  On 4/14/16, at 2/24 p.m. the social work destance (SWD) and administrator were asked for assessments and policies for resident LOAs. The SWD stated they obmpleted one community assessment and one medicine assessment. "In SWD stated they obmpleted one community assessment and one medicine assessment." The SWD stated when they knew R16 was drinking, she had called the case manager (LICSWI), 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 (LICSWI), 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  The SWD stated when they knew R16 was an own storm you let them go." The SWD stated 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			24E150	B. WING				
RAND AVENUE REST HOME    SUMMARY STATEMENT OF DEFICIENCIES	NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS CITY STATE ZIP CODE	1 0-1/	10/2010	
IXA1   D   SUMMARY STATEMENT OF DEFICIENCIES   CACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION POPERATOR (CACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CARDS HEREBUCED TO THE APPROPRIATE   CORRECTION SHOULD BE CARDS HEREBUCED TO THE APPROPRIATE	TO AVIL OF T	TIOVIDEIT OIT OOI 1 EIEIT			• • • • • •			
SALID   SUMMARY STATEMENT OF DEFICIENCIES   DECARD DEFICIENCY MIST SER PECCEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX   PROVIDERS PLAN OF CORRECTION COMPLETION   PROVIDERS PLAN OF CORRECTION   PROVIDERS PLAN OF CRUSS PROVIDERS PLAN OF CRUSS PLAN OF CRUSS PROVIDERS PLAN OF CRUSS PLAN OF CRUSS PROVIDERS PLAN OF CRUSS PROVIDERS PLAN OF CRUSS PLAN OF CRUSS PROVIDERS PLAN OF CRUSS PLAN OF CRUSS PROVIDERS PLAN OF CRUSS PROVIDERS PLAN OF CRUSS PROVIDERS PLAN OF CRUSS PLAN OF CRUSS PLAN OF CRUSS PROVIDERS PLAN OF CRUSS PROVIDERS PLAN OF CRUSS P	GRAND A	AVENUE REST HOME	<u> </u>					
First TAG  FOR TAGE REGULATORY OR LSC IDENTIFYING INFORMATION)  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 LOAs. Tile SWD stated the residents, "sign LOA-form and ask for meds". The SWD stated they completed one community assessment and one medicite 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 boyriend.  After the elopement the facility lacked reassessments on R16's ability to continue with LOAs. 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 "Wa can't restrict them from son worm you let them go." The SWD stated					MINNEAPOLIS, MN 55409			
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 who end (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	PRÉFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX	( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETION	
night." The case manager wanted her here for 1 week without any outings, then just day outings	F 323	continued therapy fineeds clinic involved II. "[R16] was adminication. During connon-compliant with alcohol on premise notification. Althoug appointment & trea improvement."  On 4/14/16, at 2:42 (SWD) and administ assessments and pSWD stated the result assessments. The one community assessment. "If sorthe outing, I have the At 3:00 p.m. the SWD ability was usual LOA. The SWD state to the case manage and the resident has self-administration. LOA assessment. The SWD stated with drinking, she had controlled the boyfriend. After the elopement reassessments on LOA's. SWD stated with the self-administration. In the self-administration. In the self-administration. It is searched the boyfriend. After the elopement reassessments on LOA's. SWD stated going out legally. The search assessments on LOA's. SWD stated going out legally. The search assessments on LOA's. SWD stated going out legally. The search assessments on LOA's. SWD stated going out legally. The search assessments on LOA's. SWD stated going out legally. The search assessments on LOA's. The search assessments on LOA's. SWD stated going out legally. The search assessments on LOA's. SWD stated going out legally. The search assessments on LOA's. SWD stated going out legally. The search assessments on LOA's. SWD stated going out legally. The search assessments on LOA's. SWD stated going out legally. The search assessments on LOA's. The search assessments as the search assessments on LOA's. The search assessments are search as the search assessments and provide the search as the searc	or chemical dependency, ement for management of DM nitted on 11/9/15, from FVR urse of stay, resident remained facility rules, concerning and leaving facility without the compliant with medical thent programs on course of a p.m. the social work designee strator were asked for colicies for resident LOA's. The sidents, "sign LOA form and SWD stated they completed dessment and one medicine meone does not return from the missing person's protocol." VD stated the assessment for ally a doctors order for the sted sometimes she would talk the rif they had one (LICSW), and to pass medication. The facility did not have a salled the case manager. R16's room, and searched the facility lacked R16's ability to continue with the side of the search of the side of the search of the sted want to go [out] even in a them go." The SWD stated they [R16] had to be there at the sanager wanted her here for 1	F3	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		' IDENTIFICATION NUMBED:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		24E150	B. WING			C / <b>18/2016</b>	
	PROVIDER OR SUPPLIER  AVENUE REST HOME	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		10,2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 323	The IDON was not scheduled phone of on 4/15/16 at 2:00 not have notes with contradict herself, lintoxication and was because of that "I gadult) no matter what the leave of about was based on community safety to stated she only wow would give bullet propaperwork and the R6 was observed of walking from dining off the living room. Stumbling and readusing any device to During random observed wand stumbling into chair in the smoking again observed to smoking room.  R6's Grand Avenue Prevention Plan (A indicated potential problems, dizzines clothing and foot we R6 had multiple fal reported, "Sometim I fall."  The interventions li	others or boyfriends. available in the facility, so a conversation occurred with her p.m The IDON stated she did n her and did not want to but R16 had alcohol as admitted to the hospital guess, she is VA (vulnerable nat." The IDON further stated beence was not an assessment other assessments such as hat the SWD did. The IDON rked one day per week, she bints to SWD who filled out n the IDON signed her name.  on 4/12/16, at 6:35 p.m. groom table to bathroom, just R6 had a halting gait, was ching for furniture. R6 was not be assist with ambulation.  servation 4/13/16, at 11:40 a.m. walking without a cane, limping the smoking room. R6 fell into groom. At 12:41 p.m. R6 was stumble and fall into a chair in  e. Residence Accident PP) completed 8/18/15, problems included balance s, poor choices regarding ear, and not wearing glasses. Is in previous year and R6 nes I get dizzy I don't know why sted on the APP included wearing pants, proper fitting	F 3.	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	CON	(X3) DATE SURVEY COMPLETED	
		24E150	B. WING			C / <b>18/2016</b>	
	PROVIDER OR SUPPLIER  AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 323	footwear, walker wilight in bathroom, a APP indicated R6 c wearing suspender glasses. APP was with no falls identification were identified for Interventions added 11/25/15, added in B.R. [bathroom] duused pull lite [call ligaccompany to room R6's care plan daterisk for fall due to gR6 was to utilize a Approaches listed assessment, vitals ordered, suspende glasses and proper night in bedroom. To intervention was listed on call was listed on call interventions. The 2 control of the stairs and R6 was no apparent in PN for 11/25/15, and of the stairs and R6 was instructed not bathroom was busy	then leaving the facility, night and a call light next to bed. The did not always comply with s, proper fitting shoes and reviewed by staff on 11/18/15, ed and on 2/11/16, two falls 11/25/15, and 1/4/16. It to the APP and dated cluded, "do not use upstairs ring noc [night]. If B.R. being ght] for nurse to assist in to use B.R."  Ed 8/26/15, indicated R6 was at ait, medications, and vision. Walker when out of the facility. On care plan included Fall risk three times weekly, labs as rs if wearing pants, wear footwear, and night light on at The 11/25/15, fall with new ted on care plan. The 1/4/16, are plan with no new 2/22/16, fall was not on care  Record and Progress Notes irrough 4/13/16, indicated R6 25/15, 1/4/16, and 2/22/16.  9:00 a.m. indicated R6 tripped ne ground and fell on the ave a walker with her. There	F 32	3			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		24E150	B. WING _			C / <b>18/2016</b>	
	PROVIDER OR SUPPLIER  AVENUE REST HOME	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP COI 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		10,2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 323	the smoke room. Redown when the charles on 2/22/16, at roommate informed in the bathroom. Redother on her left arm about then and fell on her kneed on her left arm about the sitting blood pressure was faxed to the physician record lacked any for physician 28 millimedrop in systolic blood pressure of 1 hypertensive medical Ref's quarterly Minit 2/5/16, indicated Ref was independent we except dressing an also indicated Ref with sitting to standing of any mobility device breath with walking diagnoses of anem schizophrenia.  The Physician's ord Ref received amlod benazepril for hyper clozapine for schizomedical record was that the facility look	_	F 32	23			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		24E150	B. WING			18/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIUE DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	interim director of rinvestigated and cainterventions identification. The package insert revised on 5/2012, Surgical Supply DE noted the following are mild or moderallegs or ankles, tirect stomach pain, naus warm feeling in you arrhythmia (irregular palpitations (very father the package insert Pharmaceutical Lal 8/2/13, insructed stoaregivers about the hypotension and syperiod of initial dos strictly follow the cli instructions for dos patients to consult they feel faint, lose or symptoms sugges arrhythmia."  The Centers for Disting the section for Stoplinjuries (STEADI) ressure to be "dromm Hg, or in diastor."	4/15/16, at 2:19 p.m. the surses (IDON) said, all falls are are planned with new fied.  If for amlodipine besylate by Lake Erie Medical & A Quality Care Products LLC side effects. Most side effects te: headache, swelling of your dness, extreme sleepiness, sea, dizziness, flushing (hot or ar face), ar heartbeat) and heart	F 323			
		al." R6 had both drops in I the medical record lacked he physician.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24E150	B. WING _		C <b>04/18/2016</b>		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	10/2010	
GRAND A	VENUE REST HOME			3956 GRAND AVENUE SOUTH			
				MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC  (EACH CORRECTIVE ACTION SHOUL)  CROSS-REFERENCED TO THE APPROF  DEFICIENCY)	D BE	(X5) COMPLETION DATE	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		00208	B. WING		04/1	8/2016
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S IND AVENUE	STATE, ZIP CODE		
GRAND	AVENUE REST HOME		OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
3 000	INITIAL COMMENT	ΓS	3 000			
	****ATTENTIC					
	BOARDING CAP LICENSING CORP					
	144A.10, this correspursuant to a surver found that the deficiency herein are not correspond to corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated ducorrected.	hether a violation has been compliance with all a rule provided at the tagule number indicated below. In several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ament of a fine even if the item uring the initial inspection was				
	that may result fron orders provided tha the Department wit	hearing on any assessments non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	the State Licensing federal software. Ta	nent of Health is documenting Correction Orders using ag numbers have been tota state statutes/rules for				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 05/14/16

STATE FORM 6899 If continuation sheet 1 of 32 WCGU11

TITLE

(X6) DATE

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00208	B. WING		04/1	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	AVENUE REST HOME		ND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
3 000	The assigned tag n column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. The findings which are in after the statement, evidence by." Followare the Suggested Time period for Correction for Correction order. The Suggested Time period for Correction order. The Suggested Time period for Correction orders are issued.	umber appears in the far left Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the his column also includes the n violation of the state statute "This Rule is not met as wing the surveyors findings Method of Correction and rection.  RD THE HEADING OF THE	3 000			
31130	MN Rule 4655.7830 Containers; Labele	Subp. 1 Medication d containers	31130			6/9/16
	medications shall b container bearing the information stating name of drug, strent expiration dates of directions for use, r	ge in labeled containers. All e kept in their original ne original label with legible the prescription number, agth and quantity of drug, all time-dated drugs, esident's name, physician's nal issue or in the case of a				

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 2 of 32

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00000	B. WING		04/4	0/0046
		00208			04/1	8/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRAND	AVENUE REST HOME		ND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
31130	Continued From pa	ige 2	31130			
	refill, the most rece address of the licer the medications. It the boarding care r prescription numbe if these are not on t	nt date thereof, and name and nsed pharmacy which issued shall be the responsibility of nome to secure the or and name of the medication				
	by: Based on observation review, the facility for were properly label	ion, interview, and document ailed to ensure all medications ed with resident's names, nd date opened for 1 of 2		Corrected		
	Findings include:					
	storage observation improve blood suga plastic bag labeled	7 p.m. during the medication a Victoza (a medication to ars) injectable pen was in a with a first name. There was or bag. There was no date				
	3/27/16, indicated F diabetes. The MDS	imum Data Set (MDS) dated R17 had a diagnosis of indicated R17 had received even out of seven days.				
	indicated R17 was	er Sheet dated 3/24/16, to receive Victoza 1.8 ection daily at noon for				
	licensed practical n had been removed but had not been us	4/12/16, at 12:07 p.m. the urse (LPN)-A stated Victoza from the refrigerator yesterday sed yet. LPN-A said, "I do not ot have a name on it or a				

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 3 of 32

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00208	B. WING		04/1	8/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME	3956 GRA	ORESS, CITY, S IND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
31130	The Victoza manufa Novo Nordisk dated "Use a Victoza pen a used Victoza pen medicine is left in the Facility Internal Med 5/1/14, instructed stof the medications will be every two weeks." Fitems to audited for 3. All medications rhave a legible date becoming hard to remust discard as if it Facility Proper Label lacked instructions label which included directions for use.  SUGGESTED MET The director of nurse develop systems to are audited on a round medications without appropriately replaced DON or designee costaff members on the designee could devensure ongoing corrections contact the succession of	actures package insert by 13/9/15, instructed users, for only 30 days. Throw away after 30 days, even if some he pen."  If Cart Audits policy updated taff, "To ensure the accuracy administered to the residents, dications and house audited internally by nursing Policy instructed staff that included: equiring a date opened must. It is beginning to smear or ead, fix it. If it is illegible, you is expired."  Poling policy updated 5/5/12, that medications required a diresident's name and  HOD FOR CORRECTION: sing (DON) or designee could ensure all medication areas utine basis to ensure any tan appropriate label are eed/disposed of/relabeled. The ould educate all appropriate he system. The DON or elop monitoring systems to	31130			

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 4 of 32

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00208	B. WING		04/1	8/2016	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GRAND A	AVENUE REST HOME		ND AVENUE				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE	(X5) COMPLETE DATE	
31145	Continued From pa	ge 4	31145				
31145	5 MN Rule 4655.7830 Subp. 4 Medication Containers;Out of date medications		31145			6/9/16	
	Medications having shall not be used at This MN Requirements: Based on observation review, the facility for	date medications. a specific expiration date iter the date of expiration.  ent is not met as evidenced on, interview, and document ailed to ensure expired emoved from the medication		Corrected			
	storage observation was observed to be top drawer of the m with R1's name and and expired on 4/12	p.m. during medication n one vial of Lantus (insulin) stored ready for use in the edication cart that was labeled dated as opened on 3/14/16, 2/16. That was 30 days from PN-B verified the Lantus r being opened.					
	2/20/16, indicated F diabetes. The MDS	num Data Set (MDS) dated R1 had a diagnosis of indicated R1 had received ven out of seven days.					
		er Sheet dated 3/24/16, receive Lantus 15 units daily etes.					
	dated 7/15, indicate	es insert by Sanofi-Aventis ed, "Do not use Lantus after stamped on the label or 28 use it."					

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 5 of 32

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00208	B. WING		04/1	8/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME	3956 GR	ODRESS, CITY, S AND AVENUE POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
31145	stated, "I check ever is the responsibility  Facility Internal Med 5/1/14, instructed so of the medications are each resident's med medications will be every two weeks." Fitems to audited for "2. Check for and red procedures.  3. All medications rehave a legible date becoming hard to remust discard as if it SUGGESTED MET. The director of nurse develop systems to are audited on a rounded medications without the expiration date replaced/disposed designee could edumembers on the sy could develop moniongoing compliance.	4/15/16, at 3:15 p.m. LPN-A bry Friday for expired meds. It of every nurse."  d Cart Audits policy updated taff, "To ensure the accuracy administered to the residents, dications and house audited internally by nursing Policy instructed staff that included: emove expired medications. medications using proper equiring a date opened must It is beginning to smear or ead, fix it. If it is illegible, you is expired."  THOD FOR CORRECTION: Sing (DON) or designee could ensure all medication areas utine basis to ensure any tan expiration date or beyond are appropriately of/relabeled. The DON or cate all appropriate staff stem. The DON or designee toring systems to ensure	31145			
31895	MN Rule 144.651 S of HCF Bill of Right	Subd. 23 Patients & Residents s	31895			5/23/16
	Subd. 23. Serv	ices for the facility. Patients				

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 6 of 32

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			,			
		00208	B. WING		04/1	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	AVENUE REST HOME		ND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
31895	Continued From pa	ge 6	31895			
31890	and residents shall for the facility unless for therapeutic purp goal-related in their This MN Requirements:  This MN Requirements:  This MN Requirements:  Based on observative review, the facility of the facility of the facility, did so plan, and were paid plan, and week, because the person in the kitcher received a payched she passed out the paid cash. R17 also out on weekends. Find the plan plan plan plan plan plan plan plan	not perform labor or services is those activities are included poses and appropriately individual medical record.  The performed as evidenced on interview and document ailed to ensure 2 of 2 residents ample who performed services of according to an established at a prevailing rate.  The performed as evidenced on interview and document ailed to ensure 2 of 2 residents ample who performed services of according to an established at a prevailing rate.  The performed services of according to an established at a prevailing rate.  The performed services of according to an established at a prevailing rate.  The performed services of according to an established at a prevailing rate.  The performed services of according to an established at a prevailing rate.  The performed services of according to an established at a prevailing rate.  The performed services of according to an established at a facility had hired a new staff en. When asked whether she are the facility, R17 said trays Monday-Friday and was obtained the trays and stated she was gone down. During a follow up on 4/15/16, at 10:49 a.m., R17 every other Monday.  The performed services are included at 10:30 and produced a calendar and R13 passed trays in the dietary manager stated she that volunteered and stated the state of the performed and stated the performed and stated the performed and stated the performed according to the performed according to the performed and stated the performed according to the	31895	Corrected. Also disputing the information that triggered this correction order		

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 7 of 32

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00208	B. WING		04/1	8/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	AVENUE REST HOME		ND AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
31895	the job only lasted for During the survey a interview R13 hower R17's care plan dat plan dated 10/20/15 either resident to be plans for both resident was perfor whether the resident services, and whether the work arrangement The facility's payroll 3/14/16, going forward.	or ten minutes.  Ittempts were made to ever, R13 was unavailable.  ed 10/6/15, and R13's care of the faction of the care ents lacked any evidence the ming services for the facility, at was getting paid for the ner the resident had agreed to				
	for Meal Set Up dat had signed. R17 ha and R13 had signed indicated the reside meal set-up, would and would follow inform lacked any indresident was being any plan for their he individualized plans.  On 4/15/16, at 4:15 designee (SWD) ar interviewed. The SV residents had come both were either pathe services render verified R17's and Farrangement, and the services with the services render arrangement, and the services render that the services render were services render arrangement, and the services render that the services render were services render that the services render were services render that the services render were services render that the services rend	d forms, Resident Volunteer ed 3/11, which both residents d signed a form on 5/24/12, d on 1/8/15. The information ents agreed to volunteer for be observed once a quarter, fection control guidelines. The lication as to whether either paid to perform the service, or elp having been added to their of care.  p.m. the social worker ad administrator were ND acknowledged the to her to ask for jobs and that id cash, or with gift cards, for ed in the kitchen. The SWD R13's desire to work, work the assigned kitchen duties ed on their plans of care.				

6899

Minnesota Department of Health STATE FORM

WCGU11 If continuation sheet 8 of 32

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00208	B. WING	<del></del>	04/1	8/2016
NAME OF PR	OVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAND AV	ENUE REST HOME		ND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
31990 M 31990 M M	nursing (DON) or downs a system in playork for the facility assessment, care postatus. The DON or staff are aware of the procedures. The DO monitoring systems compliance.  TIME PERIOD FOF 21) days  MN Rule 626.557 Swaltreatment of Vulus Allereatment of Vulus and the deaf or other considered an oral extent possible, the content to identify the content to identify the caregiver, the naturnal maltreatment, any emaltreatment, any emaltreatment, the naturnal maltreatment, and any other porter believes must be porter believes must be suspected malting the comply with this subsection 144.335, to comply with this subsection with the suspection of the comply with this subsection with the suspection 144.335, to comply with this subsection with this subsection with the suspection of the suspection of the suspection 144.335, to comply with this subsection with this subsection with the suspection with this subsection with this w	of Correction: The director of esignee could ensure there ce to ensure no resident's without appropriate lanning and pay/volunteer designee could ensure all the facility policies and DN or designee could develop to ensure ongoiong  A CORRECTION: Twenty One ubd. 4 Reporting nerable Adults  and oral report to the common at telecommunications device similar device shall be report. The common entry re written reports. To the report must be of sufficient the vulnerable adult, the end extent of the suspected evidence of previous ame and address of the late, and location of the her information that the light be helpful in investigating reatment. A mandated se not public data, as defined different necessary to	31895			6/9/16

6899

Minnesota Department of Health STATE FORM

WCGU11 If continuation sheet 9 of 32

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00208	B. WING		04/1	8/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME	3956 GR	ODRESS, CITY, S AND AVENUE POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
31990	Continued From particles and continued From p	ge 9 on, interview and document ailed to report allegations of es of unknown origin, nee abuse within the facility, nificant injury for 5 of 17 R16, R14, R6).  The facility on 3/23/15. A MDS) annual assessment ited R20 as independent withing and intact cognition.  Safety Assessment dated at R20 had an extensive erabuse, poor decision currently attending treatment ext. The assessment further mission has used illegal ment further identified R20 able adult (VA) issues since to poor choices. Staff on the assessment indicated eracility independently.  To in R20's medical record nistrator revealed that R20 alcohol in her room which her resident (R7) going to the indicated that this eracility has occurred.	31990		of the	
	1/16-4/11/16 and re R20 was found to b Emergency Medica activated, the reside	es were reviewed from vealed on 2/3/16 at 7:30 a.m. e lethargic and unresponsive. I Services (EMS) were ent was provided Narcan everses some overdoses d transported to the				

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 10 of 32

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00208	B. WING		04/1	8/2016
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GRAND	AVENUE REST HOME		ND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
31990	emergency room. F. Hospital Discharge indicated that R20 v for altered mental soverdose.  R20's Mental Health 3/5/16-4/5/16 indicated history of heroin ab abuse" and staff has overdose was susp summary further incaltercation with anofamily member and monitored by staff". identified a history of heroin overdose an now had and order.  Interview with the Son 4/14/16 at 2:42 paware of R20's hero SWD was unaware hospitalizations due asked if R20's hero hospitalization was The SWD replied that be reported, ever flow chart".  Interview with the Ir (IDON) on 4/15/16 was the nurse work was aware of R20's unaware why R20 v morning. The IDON with R20 having an drug use prior to 2/3 drugs in the facility.	R20 was admitted. R20's Summary dated 2/8/16 was admitted to the hospital tatus and accidental heroin  In Summary dated atted that R20 had a "lengthy use and methamphetamine d an order for Narcan if ected. The mental health dicated that R20 had a verbal ther resident and resident's "needs to be closely R20's careplan dated 3/3/16 of heroin addiction-recent d indicated that the facility for Narcan.  Ocial Worker Designee (SWD) o.m. revealed that she was bin overdose on 2/3/16. The if R20 had any other at overdose. The SWD was	31990			

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 11 of 32

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		DATE SURVEY COMPLETED	
		00208	B. WING		04/1	8/2016	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 04/1	<u>5/2010</u>	
	AVENUE REST HOME	. 3956 GRA	ND AVENUE	SOUTH			
	T	MINNEAP	OLIS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
31990	Continued From page 11		31990				
	replied "I don't know	v".				1	
	R7 was admitted to diagnoses that includisorder, schizophr R7's Minimum Data assessment dated was intact and was daily living.  R7's careplan dated adult (VA) issues of behavior and chem decisions. The carefacility dated the alcohol from R11 p.m. R7 was founable to sit up in bwas called and R7 hospital. She returned the alcohol from R17. An emergency admission sheet dathat R7 was hospital R7's social service reviewed and indicated worker designee (Sthe drinking incidental R7 got angry and standard referrational data and re	the facility on 9/30/14 with uded but not limited to mood enia, and alcohol dependency. a Set (MDS) quarterly review 1/5/16 indicated R7's cognition independent with activities of d 10/19/15 included vulnerable history of promiscuous ical use making poor e plan identified 12-28-16 (sicre plan as the year 2016) R7 that resulted in hospitalization. It is were reviewed from and revealed on 12/27/15 at bund with a "blank stare ped" and slurred speech. 911 was transported to the ned 12/28/15. R7 reportedly in her roommates R20 and y department hospital ated 12/17/15 which indicated alized for alcohol intoxication.  Progress notes were also ated on 1/4/16 the social ated on 1/4/16 the social ated on 1/4/16 the social ated on 1/4/16 with R7 regarding it and resulting hospitalization. Creamed "that was not me".  It included a psych al dated 1/11/16 which nat R7 was hospitalized for . Roommate gave her alcohol					

Minnesota Department of Health STATE FORM

WCGU11 If continuation sheet 12 of 32

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00208	B. WING		04/1	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	AVENUE REST HOME		ND AVENUE			
	OLD MAA DV OTA		OLIS, MN 5		N. 1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOUL  CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETE DATE
31990	Continued From pa	ge 12	31990			
31990	An interview with th 4/14/16, at 4:03 p.m familiar with R7's ch The SWD stated th problem, just becausif it was an ongoing problem on the care administrator confirmesulting hospitalizate agency. The assincident was "not resolved the chart for reporting agency.  An interview with the chart for reporting agency.  An interview with the chart for reporting agency.  An interview with the facility mit should be reported thought the facility mit should be reported to the care daily. The Care Area Assindicated R16 was indicated R16 was	e SWD and administrator on indicated the SWD was nemical dependency issues. The alcohol use was "not a use something happens once, issue I would have put it as a replan". The SWD and med the alcohol use and attion were not reported to the administrator stated the required to be reported, even if at the facility followed a flow of incidents to the state.  The swd and med the alcohol use and attion were not reported to the administrator stated the required to be reported, even if at the facility followed a flow of incidents to the state.  The swd and self administrator of Nursing at 2:28 p.m. revealed she reported the incident to "where deported the self to the facility mitment for chemical flinimum Data Set (MDS) reated R16 was cognitively reserved to the same of the system of t	31990			
	R16 was found to b resident was taken ambulance. The ho	otes on 11/17/15, at 6:00 p.m. e lethargic and confused. The to the emergency room via spital reported an alcohol level 5, it was documented that R16				

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 13 of 32

winnesc	<u>ita Department of He</u>	eaith				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00208	B. WING		04/18/2016	
		00208	D. W		U4/ I	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		3956 GRA	ND AVENUE	SOUTH		
GRAND	AVENUE REST HOME		OLIS, MN 5			
	0		1			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
		,		DEFICIENCY)		
31990	Continued From pa	ge 13	31990			
	had been admitted	to the hospital. On 11/24/15,				
	R16 returned to the					
		0 R16 left via taxi to the doctor				
		with her boyfriend. She had				
		h bedtime. She stated she will				
	9	m. Although contacted				
		nd, R16 did not return to the				
		5 at 5:30 p.m. When asked				
		n for a week, R16 replied "I				
		nad to take care of."				
		mary dated 12/9/15, indicated:				
		iant with medications, had a				
		nol use and multiple chemical				
		tment programs and long				
		housing. R16 was currently				
		her boyfriend in exchange for				
	favors.	The boymend in exchange for				
		vent on LOA with her boyfriend				
		16 stated she would be back				
		2/26/15, at 6:45 p.m. R16				
		inform them she was at the				
		nd was being admitted for				
		cility verified this with the ER				
	staff.	chity vermed this with the Lit				
		of nursing (IDON) 's hand				
		scharge/Summary Information				
		ption of alcohol, left premises				
		vithout notice. Broke court				
		ghts outside of facility."				
		p.m. the social work designee				
		strator were asked for policies				
		The SWD stated the				
		A form and ask for meds."				
		ey complete one community				
		ne self administration of				
		ment. If a resident did not				
		ng, she would utilize the				
	missing person pro					
		overdoses were reported to				
		ne SWD stated they were "Not				
	ine state agency, th	ie ovvo stated they were 1901				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMPI		
			A. BOILDING.			
		00208	B. WING		04/1	8/2016
NAME OF PROVIDER	R OR SUPPLIER			STATE, ZIP CODE		
GRAND AVENUE	REST HOME	•	ND AVENUE OLIS, MN 5			
	ACH DEFICIENC	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
require follow The ID schedu IDON consid vulners. The fa intoxic report SA ever police. Policy. The fa Maltre indicat form o of physic form o punish. The police potenti. "Indivinclude with go safety". "If ma admini. "The aflowch require. "Nurs whish needs Admini"	a flow chart.' ON was not uled phone of at 2:00 on 4/ered R16 an able adult (Vacility failed to ation to the Sthe elopement hough the on 12/10/15  cility's policy atment Prevent at the farment of maltreatment is issessment with the farment of the overall and appeared in the overall	rted, even if hospitalized. We	31990			

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 15 of 32

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00208	B. WING		04/1	8/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME	3956 GRA	DRESS, CITY, S AND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
31990	available" -"You must make your Administrator immessafety. The facility reportable incidents MDH".  R14 quarterly Mining she was cognitively with all activities of dated 2/23/16 ident and indicated no your A review of facility particles of dated 2/23/16, R14 had be by another resident day. The noted indicupsetting" to R14. A indicated R14 had derogatory names be (every day). R14 streecently as the previous other residents and that resident up. R the situation, but not buring a subsequent 10:22 a.m., R14 state house yells all the to deal with."  During an interview social work designer responsible for han abuse and abuse a resident had concernication.	cour report directly to the facility ediately after ensuring resident is responsible to report all and suspected crimes to and suspected crimes to num Data Set (MDS) indicated intact and was independent daily living. R14's care plan ified her as a vulnerable adult illnerable adult issues.  Progress notes indicated in een called a derogatory name in the facility three times that cated "this incident was very a progress note dated 4/12/16 complained of being called by another resident "qday" tated it had happened as	31990			

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 16 of 32

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00208	B. WING		04/1	8/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME	3956 GRA	DRESS, CITY, S			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
31990	whether it's happen of what's happening "reporting to the sta answer." She stated resident's is not repand takes place "frethreat to a resident.  R6's quarterly Mining 2/5/16, indicated R6 delusions (fixed falsindependent with ald dressing and perso indicated R6 was ussitting to standing of any mobility devices breath with walking diagnoses of anem schizophrenia. Diagretardation noted of 4/14/15.  R6's care plan date vulnerable adult and and 2/16/16, indicated issues. 12/23/15, te "Fx [fracture]. of profinger (etiology unk it happened)"  Observation on 4/12 R6 walking without into the smoking room. At 1 observed to stumblismoking room.  Review of Incident/4/21/15, at 11:29 a.	ning, or if it is their perception g." The SWD further stated, ate agency isn't always the diverbal aggression between portable to the state agency equently" but are not an actual				

Minnesota Department of Health
STATE FORM

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00208	B. WING	<del></del>	04/1	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•	
GRAND	AVENUE REST HOME	•	ND AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	OLIS, MN 5 ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
31990	eye all puffy and 2 s R [right] eye. She d happened." Type of abrasion, and swell staff did not know w resident did not rem /Accident report did or state agency wer  Nurses Record and 4/21/15, at 12:00 p. [patient] fell against [night], has a swolle and two small lacer long around eye." "I fell against."  Note dated 4/21/15 [complaining of] (ur States hit head on o to help guide her." 4/21/15 through 4/2 administrator or SA unknown origin.  Nurses Record and 12/23/15 at 1:30 p.r office and showed in noted bruising on the minor swelling. R6  Physician's Progres indicated R6 is in cl bruising and swellin not remember hittin note indicated X-ray	sm [small] lacerations around oes not remember how it injury listed as "hematoma, ing." Incident form indicated when injury happened and nember falling. Incident I not indicate the administrator re informed of the injury.  I Progress Notes dated m. indicated: "Appears pt something during the nocen right eye under each eye ations are 3 mm [millimeters]. Does not remember what she door going to BR-has flashlight Review of progress notes 17/15, did not indicate the were notified of the injury of I Progress Notes dated m. indicated R6 came into nurse her left hand. Nurse he front and back of hand with was sent to urgent care.  Is Notes dated 12/23/15, inic for assessment of a go of left hand and that R6 did and hand or banging it. Progress y showed fracture of proximal finger splint placed and	31990			

6899

Minnesota Department of Health STATE FORM

-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	
		00208	B. WING		04/1	8/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY :	STATE, ZIP CODE	1 04/1	0/2010
	AVENUE REST HOME	. 3956 GRA	ND AVENUE	E SOUTH		
	T	MINNEAP	OLIS, MN 5	T		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
31990	Continued From pa	ge 18	31990			
31990	The Serious Injury the Office of the Or and Mental Retards sustained an fractul hand. Description indicated "resident happened. Nurse of left hand." The sunotified including mare Facility Complaints protection were bland time of the injury happened. While the was notified there was notified there was notified there was notified unknown origin.  During interview on social worker design for R6 was reported but not to the state vulnerable adult issund practical indocument notifying fracture we do not in weekend or nights. If the resident were would let them know During interview on SWD said "I don't to the administrator be adult issue, it was a would need to know vulnerable adult issue.	Report dated 12/23/15, sent to inbudsman for Mental Health ation, indicated R6 had re of the fifth finger of the left of how the injury happened does not know what bserved swelling and bruising ection triggering others to be edical, OHFC [Office of Health - state agency] and adult nk.  7 R6 was unable to state what he Office of the Ombudsman was no evidence that the state of the significant injury of to the ombudsman's office agency because they were not ues.  4/15/16, at 9:25 a.m. hurse (LPN)-A said "We do not the administrator. If there is a notify administrator on the because we have dealt with it. admitted to the hospital we	31990			

6899

Minnesota Department of Health
STATE FORM

WCGU11 If continuation sheet 19 of 32

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00208	B. WING		04/1	8/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRAND A	GRAND AVENUE REST HOME 3956 GF MINNEA			E SOUTH 5409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
31990	Continued From pa	ge 19	31990			
	During interview on administrator said, me. I expect them  During interview on interim director of n facility reported inju Reporting fractures we know where the said, "If there have is not reportable. W supposed to." Whe injuries of unknown versus the office of said, "I have always SUGGESTED MET administrator or desto ensure potential abuse/neglect/misa allegations are reportable. We supposed to administrator or desto ensure potential abuse/neglect/misa allegations are reportable.	4/15/16, at 2:15 p.m. the "I ask them to chart notifying to notify me about fractures."  4/15/16, at 2:19 p.m. the surses (IDON) stated, the prices of unknown origin, depended on whether or not resident had been. The IDON not been any incidents then it be report to where ever we are not asked about reporting origin to the state agency the ombudsman the IDON is reported to the same place."  THOD OF CORRECTION: The signee could develop systems appropriation of funds orted immediately to the tate agency. The administrator educate all staff om this istrator could monitor to				
32000	MN Rule 626.557 S Maltreatment of Vul		32000			6/9/16
	Subd. 14. Abuse	e prevention plans.				
	and personal care a shall establish and	cept home health agencies attendant services providers, enforce an ongoing written lan. The plan shall contain an				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00208	B. WING		04/1	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	AVENUE REST HOME		ND AVENUE			
(VA) ID	CLIMMADV CTA	TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	ON.	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
32000	Continued From pa	ge 20	32000			
52000	assessment of the penvironment, and its which may encoura statement of specifi minimize the risk of with any rules gove the licensing agence.  (b) Each facility, in agency and personal providers, shall dev prevention plan for there or receiving shall contain an ind the person's risk of adults; and (3) state measures to be tak abuse to that person adults; and (3) state measures to be tak abuse to that person adults; and personal care a knows that the vuln violent crime or an atoward others, the inplan must detail the minimize the risk the reasonably be experiacility and persons unsupervised. Undo f a vulnerable adult misconduct or phys such information from authority or through another facility, and	chysical plant, its is population identifying factors ge or permit abuse, and a comeasures to be taken to abuse. The plan shall comply ming the plan promulgated by your cluding a home health care all care attendant services elop an individual abuse each vulnerable adult residing ervices from them. The plan invidualized assessment of: (1) eptibility to abuse by other gother vulnerable adults; (2) abusing other vulnerable ements of the specific en to minimize the risk of n and other vulnerable adults. It this paragraph, the term				

6899

Minnesota Department of Health STATE FORM

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00208	B. WING		04/1	8/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 01/1	0/2010
GRAND	AVENUE REST HOME	3956 GRA	ND AVENUE	E SOUTH		
GITAIL		MINNEAP	OLIS, MN 5	T		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
32000	Continued From pa	ge 21	32000			
32000	vulnerable adult.  This MN Requirements: Based on observation review, the facility for policy for reporting injuries of unknown abuse within the fact significant injury for R16, R14, R6).  Findings include: The facility's policy Maltreatment Prevention of maltreatment of physical, verbal, form of meglect, inversible prior to adoptentially dangerous and potentially dangerous "Individual suscept included in the overwith goals and approafety".  "If maltreatment is administrator must administrator must administrator must "The administrator flowchart to determine to the policy and potentially dangerous and approafety".  "If maltreatment is administrator must administrator must "The administrator flowchart to determine to determine to the policy is a collened to be submit to determine the policy is a collened to be submit to determine the policy is a collened to be submit to determine the policy is a collened to be submit to determine the policy is a collened to be submit to determine the policy is a collened to be submit to determine the policy is a collened to be submit to determine the policy is a collened to be submit to determine the policy in the	ent is not met as evidenced on, interview and document ailed to operationalize their of allegations of verbal abuse, origin, elopement, substance cility, and/or falls with 5 of 17 residents (R20, R7,  entitled "Vulnerable Adult ention Plan" dated 3/6/15, acility "does not tolerate any nt" which included "any form mental or sexual abuse; any oluntary seclusion, corporal handling of resident property". uded the following: will be made of a prospective mission for a known history of us behavior patterns" cibility will be assessed and rall resident careplan along roaches for prevention and suspected or observed the be notified immediately". or representative will use the ine the reporting s the internal reporting forms ection of information that ted to MDH online. The	32000	Corrected.		
	flowchart to determ requirements"Nursing complete whish [sic] is a colle needs to be submit Administrator subm	ine the reporting s the internal reporting forms ection of information that				

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 22 of 32

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION :	(X3) DATE COMP	SURVEY LETED
		7. BOILDING	•		
	00208	B. WING		04/1	8/2016
NAME OF PROVIDER OR SUPPLIE			STATE, ZIP CODE		
GRAND AVENUE REST HON	1 E	ND AVENUI OLIS, MN 5			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
Administrator imm safety. The facility reportable incider MDH".  Based on observative facility verbal abuse, injue lopement, substand/or falls with stresidents (R20, FR20 was admitted minimum data sedated 2/6/16 identactivities of daily R20's Community 8/3/15 indicated thistory of substanding, and was three times per windicated "since adrugs". The assend multiple vulneadmission related recommendations R20 could leave to A note dated 12/2 signed by the adradmitted to having contributed to an emergency room was not the first to R20's progress not 1/16-4/11/16 and	your report directly to the facility nediately after ensuring resident y is responsible to report all its and suspected crimes to ation, interview and document failed to report allegations of ries of unknown origin, ance abuse within the facility, ignificant injury for 6 of 17 7, R16, R14, R6, R8).  If to the facility on 3/23/15, A to the facility on 3/23/16, A to the facility on dependent with iving and intact cognition.  If Safety Assessment dated that R20 had an extensive ce abuse, poor decision currently attending treatment eek. The assessment further dmission has used illegal sament further identified R20 erable adult (VA) issues since to poor choices. Staff is on the assessment indicated the facility independently.  If the R20's medical record in the resident (R7) going to the The note indicated that this me this has occurred.  In the revealed on 2/3/16 at 7:30 a.m. be lethargic and unresponsive.	32000			

6899

Minnesota Department of Health
STATE FORM

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		00208	B. WING		04/1	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
GRAND	AVENUE REST HOME	•	ND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
32000	Emergency Medical activated, the reside (medication which is such as Heroin) and emergency room. Hospital Discharge indicated that R20 is for altered mental soverdose.  R20's Mental Health 3/5/16-4/5/16 indical history of heroin ab abuse" and staff had overdose was susp summary further incaltercation with anofamily member and monitored by staff". identified a history of heroin overdose and now had and order.  Interview with the Son 4/14/16 at 2:42 paware of R20's herosidalizations due asked if R20's herohospitalization was The SWD replied that to be reported, ever flow chart."  Interview with the Ir (IDON) on 4/15/16, was the nurse work was aware of R20's unaware why R20 is unaware why R20 is not such as the surface work was aware of R20's unaware why R20 is not such as the surface work was aware of R20's unaware why R20 is not such as the surface work was aware of R20's unaware why R20 is not such as the surface work was aware of R20's unaware why R20 is not such as the surface work was aware of R20's unaware why R20 is not such as the surface work was aware of R20's unaware why R20 is not such as the surface work was aware of R20's unaware why R20 is not such as the surface work was aware of R20's unaware why R20 is not such as the surface work was aware of R20's unaware why R20 is not such as the surface work was aware of R20's unaware why R20 is not such as the surface work was aware of R20's unaware why R20 is not such as the surface work was aware of R20's unaware why R20 is not such as the surface work was aware of R20's unaware why R20 is not such as the surface work was aware of R20's unaware why R20 is not such as the surface work was aware of R20's unaware why R20 is not such as the surface work was aware of R20's unaware why R20 is not such as the surface work was aware of R20's unaware why R20 is not such as the surface work was aware of R20's unaware why R20 is not such as the surface work was aware of R20's unaware why R20 is not such as the surface was a surface work was a ware of R20's unaware	I Services (EMS) were ent was provided Narcan reverses some overdoses of transported to the R20 was admitted. R20's Summary dated 2/8/16 was admitted to the hospital tatus and accidental heroin.  In Summary dated at lengthy use and methamphetamine of an order for Narcan if ected. The mental health dicated that R20 had a verbal ther resident and resident's "needs to be closely R20's careplan dated 3/3/16 of heroin addiction-recent of indicated that the facility for Narcan.  Rocial Worker Designee (SWD) o.m. revealed that she was oin overdose on 2/3/16. The if R20 had any other at to overdose. The SWD was	32000			

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 24 of 32

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00208	B. WING		04/1	8/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME	3956 GRA	DRESS, CITY, S AND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
32000	with R20 having an drug use prior to 2/3 drugs in the facility. should be reported replied "I don't know R7 was admitted to diagnoses that includisorder, schizophr R7's Minimum Data assessment dated was intact and was daily living.  R7's careplan dated adult (VA) issues of behavior and chem decisions. The care facility dated the caconsumed alcohol of R7's progress notes 10/21/15-4/11/16 as 9:11 p.m. R7 was founable to sit up in bwas called and R7 hospital. She return got the alcohol from R17. An emergency admission sheet dathat R7 was hospital R7's social service reviewed and indicated worker designee (Sthe drinking inciden R7 got angry and service reviewed and service reviewed and service reviewed and service reviewed and indicated worker designee (Sthe drinking inciden R7 got angry and service reviewed and service	y similar incidents related to 3/16 was not aware of any. When asked if this incident to the state agency the DON v".  the facility on 9/30/14 with uded but not limited to mood enia, and alcohol dependency. Set (MDS) quarterly review 1/5/16 indicated R7's cognition independent with activities of thistory of promiscuous ical use making poor plan identified 12-28-16 (sictore plan as the year 2016) R7 that resulted in hospitalization. See were reviewed from and revealed on 12/27/15 at bound with a "blank stare led" and slurred speech. 911 was transported to the led 12/28/15. R7 reportedly in her roommates R20 and y department hospital ted 12/17/15 which indicated alized for alcohol intoxication.  progress notes were also atted on 1/4/16 the social WD) spoke with R7 regarding that and resulting hospitalization. Creamed "that was not me".	32000			

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00208	B. WING		04/1	8/2016
NAME OF PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 0.71	0,2010
GRAND AVENUE REST HOME	3956 GR	AND AVENUE			
GRAND AVENUE REST HOME	MINNEAF	POLIS, MN 5	5409		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
32000 Continued From page	ge 25	32000			
included the note the alcohol intoxication. That was hidden in the A/14/16, at 4:03 p.m. familiar with R7's chamiliar with the problem, just becaute if it was an ongoing problem on the care administrator confirmed the confirmed was accepted and the chart for reporting of agency.  An interview with the (IDON) on 4/15/16 at thought the facility mit should be reported R16 was accepted and 11/9/15, under commit dependency. The M dated 12/7/15, indictinated, mildly depressive symptoms directed care daily. The Care Area Asset indicated R16 was medications for anx The undated care pamissing person reportacility at specified the leaves of absence (medications.	nat R7 was hospitalized for Roommate gave her alcohol he room.  e SWD and administrator on in indicated the SWD was nemical dependency issues. The elacohol use was "not a rise something happens once, issue I would have put it as a replan". The SWD and med the alcohol use and reported to the administrator stated the required to be reported, even if at the facility followed a flow of incidents to the state  e Interim Director of Nursing at 2:28 p.m. revealed she reported the incident to "where				

Minnesota Department of Health STATE FORM

DRM WCGU11 If continuation sheet 26 of 32

PRINTED: 08/26/2016 FORM APPROVED

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
7.110 1 27.11	or connection	BEITH IOMIGITIES	A. BUILDING:		0011111	
		00208	B. WING		04/1	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CDAND	AVENUE DECT HOME	3956 GRA	ND AVENUE	SOUTH		
GRAND	AVENUE REST HOME	MINNEAP	OLIS, MN 5	5409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
32000	Continued From pa	ge 26	32000			
32000	R16 was found to be resident was taken ambulance. The ho of 0.37. On 11/18/1 had been admitted R16 returned to the On 12/8/15, at 10:0 and spend the day medications through be back at 10:00 p. through her boyfrier facility until 12/15/1 why she didn't returned some things I had som	e lethargic and confused. The to the emergency room via spital reported an alcohol level 5, it was documented that R16 to the hospital. On 11/24/15, facility.  O R16 left via taxi to the doctor with her boyfriend. She had h bedtime. She stated she will m. Although contacted nd, R16 did not return to the 5 at 5:30 p.m. When asked n for a week, R16 replied "I	32000			

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 27 of 32

PRINTED: 08/26/2016 FORM APPROVED

Minnesota Department of Health

STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE :	
		00208	B. WING		04/1	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	_	
GRAND	AVENUE REST HOME		ND AVENUE			
240.15	CLIMMA DV CTA		OLIS, MN 5		DNI .	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
32000	Continued From pa	ge 27	32000			
32000	return from the outinissing person pro When asked if the othe state agency, the required to be reported follow a flow chart." The IDON was not scheduled phone of IDON at 2:00 on 4/considered R16 and vulnerable adult (Warthe facility failed to intoxication to the Streport the elopeme SA even though the police on 12/10/15 R14 quarterly Mining she was cognitively with all activities of dated 2/23/16 identicant and indicated no vulnerable adult (Varthe facility particles) and indicated no vulnerable at the strength of the police on 12/10/15 R14 quarterly Mining she was cognitively with all activities of dated 2/23/16 identicated 2/23/16 identicated 2/23/16 identicated R14 had be derogatory names (every day). R14 streeently as the previous at the previous and that resident up. R the situation, but not buring a subsequent the state of the previous and that resident up. R the situation, but not buring a subsequent the state of the previous and that resident up. R the situation, but not buring a subsequent the state of the previous and that resident up. R the situation, but not buring a subsequent the previous and that resident up. R the situation, but not buring a subsequent the state of the previous and	ng, she would utilize the tocol. Diverdoses were reported to be SWD stated they were "Not rted, even if hospitalized. We available in the facility, a conversation occurred with 15/16. The IDON had not elopement, but she was a A), "I thought it was reported." report R16's alcohol 6A. The facility also failed to not from 12/8-12/15/15 to the facility reported it to the as a missing person. In the facility indicated intact and was independent daily living. R14's care plan ified her as a vulnerable adult allnerable adult issues.  Progress notes indicated in the facility three times that cated "this incident was very a progress note dated 4/12/16 complained of being called by another resident "qday" tated it had happened as	32000			

6899

Minnesota Department of Health STATE FORM

PRINTED: 08/26/2016 FORM APPROVED

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00208	B. WING		04/1	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	AVENUE REST HOME		ND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
32000	Continued From pa	 .ge 28	32000			
32000	house yells all the tito deal with."  During an interview social work designeresponsible for han abuse and abuse a resident had conceperson. She stated whether it's happen of what's happening "reporting to the state answer." She stated resident's is not repand takes place "frethreat to a resident.  R6's quarterly Mining 2/5/16, indicated R6 delusions (fixed falsindependent with all dressing and perso indicated R6 was unsitting to standing of any mobility devices breath with walking diagnoses of anemischizophrenia. Diagretardation noted of 4/14/15.  R6's care plan date vulnerable adult and and 2/16/16, indicated issues. 12/23/15, te "Fx [fracture]. of profinger (etiology unknit happened)"	ime and is "bossy" and "hard on 4/15/16, at 2:15 p.m. the ee (SWD) stated she was dling and reporting potential llegations. She stated when a rns she would talk to the other "you have to separate hing, or if it is their perception g." The SWD further stated, hate agency isn't always the d verbal aggression between bortable to the state agency equently" but are not an actual formum Data Set (MDS) dated formum Data Set (MDS) dated formum Data Set (MDS) dated				

Minnesota Department of Health STATE FORM

WCGU11 If continuation sheet 29 of 32

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMPI	
		00208	B. WING		04/1	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
GRAND	AVENUE REST HOME		ND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
32000	R6 walking without into the smoking room. At 1 observed to stumble smoking room.  Review of Incident/4/21/15, at 11:29 a. hours p[after] being eye all puffy and 2 s R [right] eye. She d happened." Type of abrasion, and swell staff did not know w resident did not rem/Accident report did or state agency wer  Nurses Record and 4/21/15, at 12:00 p. [patient] fell against [night], has a swolle and two small lacer long around eye." "I fell against."  Note dated 4/21/15 [complaining of] (ur States hit head on othelp guide her." 4/21/15 through 4/2 administrator or SA unknown origin.  Nurses Record and	ge 29 a cane, limping and stumbling om. R6 fell into a chair in the 2:41 p.m. R6 was again e and fall into chair in the Accident Report dated m. indicated "Pt woke up-few up we noticed her R [right] sm [small] lacerations around oes not remember how it injury listed as "hematoma, ing." Incident form indicated then injury happened and nember falling. Incident not indicate the administrator re informed of the injury.  Progress Notes dated m. indicated: "Appears pt something during the nocen right eye under each eye ations are 3 mm [millimeters]. Does not remember what she door going to BR-has flashlight Review of progress notes 7/15, did not indicate the were notified of the injury of Progress Notes dated m. indicated R6 came into	32000	DEFICIENCY)		
	office and showed r	nurse her left hand. Nurse he front and back of hand with was sent to urgent care.				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  GRAND AVENUE REST HOME  (X4) ID PREFIX TAG  CONTINUED FROM BETH TO BETICIENCY MUST BE PRECEDED BY FULL TAG  CONTINUED FROM BETH TO BETICIENCY MUST BE PRECEDED BY FULL TAG  CONTINUED FROM BETICIENCY MUST BE PRECEDED BY FULL TAG  CONTINUED FROM BETICIENCY MUST BE PRECEDED BY FULL TAG  CONTINUED FROM BETICIENCY MUST BE PRECEDED BY FULL TAG  CONTINUED FROM BETICIENCY MUST BE PRECEDED BY FULL TAG  CONTINUED FROM BETICIENCY MUST BE PRECEDED BY FULL TAG  COMPLETE DATE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  32000  Continued From page 30  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	-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER  GRAND AVENUE REST HOME  (X4) ID PREFIX TAG  (X5) ID CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  32000  Continued From page 30  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			00208	B. WING		04/1	8/2016
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  32000 Continued From page 30  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	NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	<u>,                                      </u>	0,1010
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  32000  Continued From page 30  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	GRAND	AVENUE REST HOME	-				
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	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
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."	32000	Physician 's Progreindicated R6 is in cobruising and swellin not remember hittin note indicated X-ra phalanx of left fifth orthopedic follow urecommended.  The Serious Injury the Office of the Orand Mental Retards sustained an fractur hand. Description indicated "resident happened. Nurse of left hand" The sonotified including market fracility Complaints protection were black time of the injury happened. While the was notified there was notified unknown origin.  During interview or social worker design for R6 was reported but not to the state vulnerable adult is some process of the practical document notifying fracture we do not weekend or nights. If the resident were	ess Notes dated 12/23/15, linic for assessment of ag of left hand and that R6 did ag hand or banging it. Progress y showed fracture of proximal finger splint placed and p with in next week  Report dated 12/23/15, sent to about the fifth finger of the left of how the injury happened does not know what abserved swelling and bruising ection triggering others to be redical, OHFC [Office of Health at a state agency] and adult nk.  R6 was unable to state what he Office of the Ombudsman was no evidence that the state dof the significant injury of a 4/14/16, at 10:25 a.m. the the computation of the ombudsman's office agency because they were not sues.  A 4/15/16, at 9:25 a.m. nurse (LPN)-A said "We do not the administrator. If there is a notify administrator on the because we have dealt with it. admitted to the hospital we				

Minnesota Department of Health STATE FORM

FORM WCGU11 If continuation sheet 31 of 32

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE : COMPI	
		00208	B. WING		04/1	8/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME	3956 GRA	ORESS, CITY, S IND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
32000	During interview on SWD said "I don't the administrator be adult issue, it was a would need to know vulnerable adult iss being beaten. Do not fall."  During interview on administrator said, me. I expect them  During interview on interim director of n facility reported inju Reporting fractures we know where the said, "If there have is not reportable. W supposed to." Whe injuries of unknown versus the office of said, "I have always SUGGESTED MET administrator or desto ensure the abuse operationalized. The could educate all st administrator could compliance.	ge 31  4/15/16, at 9:27 a.m. the pink they would bother calling ecause it was not a vulnerable a serious injury. [Administrator] about fractures if it were a ue like the fracture was due to be the need to know if it is due to a 4/15/16, at 2:15 p.m. the "I ask them to chart notifying to notify me about fractures."  4/15/16, at 2:19 p.m. the urses (IDON) stated, the ries of unknown origin. depended on whether or not resident had been. The IDON not been any incidents then it if e report to where ever we are en asked about reporting origin to the state agency the ombudsman the IDON is reported to the same place."  HOD OF CORRECTION: The signee could develop systems endingled plan/policy is endministrator or designee aff om this system. The monitor to ensure ongoing	32000			

6899

Minnesota Department of Health STATE FORM

#### 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

		10 22 00::11			E SOUTH ET HOEH TOT		1 delinty 12: 00200
MEDICARE/MEDICAID PROVID     NO.(L1) 24E150	ER	3. NAME AND AU (L3) <b>GRAND AV</b>				4. TYPE OF ACTI	<u> </u>
2. STATE VENDOR OR MEDICAID	NO.	(L4) 3956 GRAND AVENUE SOUTH				1. Initial 3. Termination	2. Recertification 4. CHOW
(L2) <b>950842200</b>		(L5) MINNEAPOLIS, MN			(L6) <b>55409</b>	5. Validation 7. On-Site Visit	6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	PPLIER CATEO	GORY	<u>10</u> (L7)		
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey Aft	er Compiaint
6. DATE OF SURVEY 6/30	<b>/2016</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR END	DING DATE: (L35)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID			MNG DATE. (E33)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30	
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	AS:			
From (a):		A. In Complia	ince With		And/Or Approved Waivers Of	The Following Requires	nents:
To (b):		_	equirements		2. Technical Personnel	6. Scope of S	Services Limit
		_	e Based On:		3. 24 Hour RN	7. Medical I	
12.Total Facility Beds	<b>20</b> (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	NF) A 8. Patient Ro	om Size
13.Total Certified Beds	<b>20</b> (L17)	B. Not in Comp	liance with Progr	am .	5. Life Safety Code	9. Beds/Room	m
			and/or Applied		* Code: B,8	(L12)	
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
	20						
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Gloria Derfus. Unit Sup	ervisor	7	7/8/2016	(L19) K	(amala Fiske-Downing, Hea	lth Program Represe	entative 07/8/2016 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	OFFICE OR SINGLE S	STATE AGENCY	
19. DETERMINATION OF ELIGIBII	JTY		IPLIANCE WIT	H CIVIL	21. 1. Statement of Fina	ncial Solvency (HCFA-25 ol Interest Disclosure Str	
X 1. Facility is Eligible to I	Participate	RIGH	113 AC1:		3. Both of the Above		ii (HCrA-1313)
2. Facility is not Eligible	(L21)					<del></del>	
	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	:	(L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00	<u>INVOLU</u>	<u>JNTARY</u>
03/31/1974					01-Merger, Closure		Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal		der Status Change
(L27)	D Di1 C		(L44)			00-Activ	re
	B. Rescind Si	uspension Date:	(7.45)				
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
	(L28)			(L31)			
21 DO DECEME OF CMC 1522	22	DETERMINATION	LOE ADDDOMA	DATE			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION 06/24/2016	OF APPROVAL	LDAIE			
	(L32)	VU/ 44/ 4V10		(L33)	DETERMINATION APP	ROVAL	



#### 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 South 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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,

Kumala Fiske Downing

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 SOuth 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))

Grand Avenue Rest Home June 20, 2016 Page 2

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 <a href="https://dab.efile.hhs.gov">https://dab.efile.hhs.gov</a> 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

Grand Avenue Rest Home June 20, 2016 Page 3

> 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 <a href="mailto:Tamika.Brown@cms.hhs.gov">Tamika.Brown@cms.hhs.gov</a>.

### 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc</a> 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

Grand Avenue Rest Home June 20, 2016 Page 4

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

Kamala Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

#### POST-CERTIFICATION REVISIT REPORT

24E150 Y1 B. Wing G/30/2016  NAME OF FACILITY GRAND AVENUE REST HOME STREET ADDRESS, CITY, STATE, ZIP CODE 3956 GRAND AVENUE SOUTH		MULTIPLE CONSTRUCTION  A. Building			DATE OF REV	VISIT
GRAND AVENUE REST HOME 3956 GRAND AVENUE SOUTH				Y2	6/30/2016	Y3
	NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
MININE A DOLLIS MINI EF 400	GRAND AVENUE REST HOME		3956 GRAND AVENUE SOUTH			
INITINICAPOLIS, ININ 35409			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         DATE           Y4         Y5		ITEM Y4			<b>DATE</b> Y5	ITEM Y4			DATE Y5	
ID Prefix Reg. #	F0164 483.10(e), 483.	Correction 75(I)(4) Completed	ID Prefix	F0169 483.10		Correction Completed	ID Prefix Reg. #	F0225 483.13(c)(1)(ii)-(iii	), (c)(2)	Correction Completed
LSC		05/11/2016	LSC			05/23/2016	LSC			06/09/2016
ID Prefix		Correction	ID Prefix		(d)(3), 483.10(k)	Correction	ID Prefix	F0315 483.25(d)		Correction
Reg. # LSC	483.13(c)	06/09/2016		(2)	(u)(s), 463.10(k)	Completed 06/10/2016	Reg. # LSC	465.25(U)		Completed 06/09/2016
ID Prefix Reg. #	F0323 483.25(h)	Correction  Completed		Reg. #		Correction Completed	ID Prefix Reg. #	F0356 483.30(e)		Correction Completed
LSC		06/09/2016	LSC			05/16/2016	LSC			04/18/2016
ID Prefix Reg. # LSC	F0431 483.60(b), (d), (	Correction  Completed 06/09/2016	ID Prefix Reg. # LSC	F0514 483.75		Correction Completed 06/03/2016	ID Prefix Reg. # LSC	F0520 483.75(o)(1)		Correction Completed 06/03/2016
ID Prefix Reg. #		Correction	ID Prefix Reg. #			Correction Completed	ID Prefix Reg. #			Correction Completed
REVIEWI STATE A	GENCY	REVIEWED BY (INITIALS) GD/kfd REVIEWED BY (INITIALS)	DATE 7/8/201 DATE	6	SIGNATURE OF		LSC 8623		DATE DATE	6/30/2016
	UP TO SURVE	Y COMPLETED ON		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY C JNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?					☐ YE	s 🗆 no

#### POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION  A. Building 01 - MAIN BUILDING 01			DATE OF REV	ISIT
	B. Wing	Y	2	6/3/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
GRAND AVENUE REST HOME	E	3956 GRAND AVENUE SOUTH			
		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).

ITE Y4		<b>DATE</b> Y5	ITEM Y4		<b>DATE</b> Y5	ITEM Y4			DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101		Completed
LSC	K0012	05/05/2016	LSC	K0032	05/05/2016	LSC	K0033		05/05/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #			Completed
LSC	K0039	05/05/2016	LSC	K0050	04/20/2016	LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg.#			Completed
LSC			LSC			LSC			
REVIEWI STATE A		REVIEWED BY (INITIALS) TL/kfd	<b>DATE</b> 6/20/2016		OF SURVEYOR	19251	I	DATE	6/3/2016
REVIEWI CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE		· · · · · · · · · · · · · · · · · · ·	I	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						s 🗆 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

	IAKI I-	TO BE COMIT		IIIE SIAI	LESURVETAGENCI		racinty iD. 00206
MEDICARE/MEDICAID PROVID     NO.(L1) 24E150	DER	3. NAME AND AI (L3) <b>GRAND AV</b>				4. TYPE OF	<del></del>
2. STATE VENDOR OR MEDICAID	) NO	(L4) <b>3956 GRAN</b>	D AVENUE S	0UTH		1. Initial 3. Terminati	2. Recertification ion 4. CHOW
(L2) <b>950842200</b>	, inc.	(L5) MINNEAPO	DLIS, MN		(L6) <b>55409</b>	5. Validation 7. On-Site V	n 6. Complaint
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	JPPLIER CATE	GORY	<u>10</u> (L7)		
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Surv	ey After Complaint
6. DATE OF SURVEY <b>04/1</b>	<b>18/2016</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FIGGAL VEAD	ENDING DATE (LAS)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR	ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/3	0
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	Y IS CERTIFIED	AS:			
From (a):		A. In Complia	ance With		And/Or Approved Waivers Of	The Following Red	quirements:
To (b):		_	equirements		2. Technical Personnel	6. Scop	e of Services Limit
		Complianc	e Based On:		3. 24 Hour RN	7. Med	ical Director
12.Total Facility Beds	<b>20</b> (L18)	1. A	acceptable POC		4. 7-Day RN (Rural Si	NF) 8. Patie	nt Room Size
13.Total Certified Beds	20 (L17)	X B. Not in Cor	nnliance with Pro	orram	5. Life Safety Code	🗶 9. Beds	/Room
13. Total Certified Beds	20 (E17)		and/or Applied		* Code: B, 9	(L12)	
14. LTC CERTIFIED BED BREAKDO	OWN	_			15. FACILITY MEETS	(L12)	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15	<u>(</u> )
10,514	20	ici	IID		1001 (c) (1) 01 1001 (j) (1).		,
(1.27) (1.28)		(I. 42)	(1.42)				
(L37) (L38)	(L39)	(L42)	(L43)				
17. SURVEYOR SIGNATURE  Carrie Euerle, HFE NE	Ш	Date :	06/23/2016	<sub>(L19)</sub> K	18. STATE SURVEY AGENCY  (amala Fiske-Downing, Hea		Date:  Dresentative 06/24/2016 (L20)
PA	RT II - TO BE	COMPLETED 1	BY HCFA R	` ′	L OFFICE OR SINGLE S	STATE AGENO	
19. DETERMINATION OF ELIGIBII	LITY		MPLIANCE WIT	'H CIVIL	21. 1. Statement of Fina		FA-2572) re Stmt (HCFA-1513)
_X_ 1. Facility is Eligible to l	Participate	Kidi	III3 ACT.		3. Both of the Abov		e sum (Herri-1313)
2. Facility is not Eligible							
	(L21)						
22. ORIGINAL DATE	23. LTC AGREEN	MENT 2	4. LTC AGREE	MENT	26. TERMINATION ACTION	:	(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DA	ATE	VOLUNTARY 00	<u>INV</u>	VOLUNTARY
03/31/1974					01-Merger, Closure	05-	Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-	Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	on OT	HER
		n of Admissions:			04-Other Reason for Withdrawal	·	Provider Status Change
			(L44)			00-	Active
(L27)	B. Rescind Su	spension Date:					
			(L45)				
20 TERMINIATION DATE.	20	INTERMEDIARY	/CARRIER NO		20 DEMARKS		
28. TERMINATION DATE:	29	. INTERMEDIARY	CARKIEK NO.		30. REMARKS		
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	N OF APPROVA	L DATE			
	(L32)	06/24/2016		(L33)	DETERMINATION APP	ROVAL	
	·/			(===)	DETERMINATION ALI	1.0 11L	



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 South 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:

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

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

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

at the time of a revisit;

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

<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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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

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

PRINTED: 06/23/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		24E150	B. WING _		04/	18/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 00	0		
	as your allegation on Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are our signature is not required it first page of the CMS-2567 ic submission of the POC will cion of compliance.				
	on-site revisit of you validate that substa	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with				
		vey was conducted and tion(s) were also completed at dard survey."				
	completed. The cor	complaint HE150005 was mplaint was substantiated and ited at F225, F226, F315, and				
F 164 SS=D	has been revised. 483.10(e), 483.75(l)	this statement of deficiencies 0(4) PERSONAL ENTIALITY OF RECORDS	F 16	4		5/11/16
		e right to personal privacy and or her personal and clinical				
	medical treatment, communications, po meetings of family a	cludes accommodations, written and telephone ersonal care, visits, and and resident groups, but this e facility to provide a private				
I ABORATORY	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 

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:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		24E150	B. WING		04/	18/2016	
	PROVIDER OR SUPPLIER  AVENUE REST HOMI	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CO 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 164	section, the resider release of personal individual outside to the release of personal individual outside to the resident's right and clinical records resident is transfer institution; or record. The facility must ke contained in the rest the form or storage release is required healthcare institution contract; or the rest that the form or storage release is required healthcare institution contract; or the rest that the facility is a seed on observation review, the facility is 15 residents (R2, Foroms who stated privacy.  Findings include:  R2's annual Minim 3/11/16, indicated sindependent with a During an observation R2's bedroom bed upon entrance to the parallel to and another states.	dent.  d in paragraph (e)(3) of this not may approve or refuse the I and clinical records to any the facility.  It to refuse release of personal is does not apply when the red to another health care do release is required by law.  Deep confidential all information is ident's records, regardless of the methods, except when by transfer to another on; law; third party payment	F 1	Submission of this response Correction is not a legal adm deficiency exists or that this deficiency was correctly cited not to be construed as an adfault by the facility, the Admir any employees, agents, or o individuals who draft or may in this Response and Plan of In addition, preparation and this Plan of Correction does an admission or agreement the facility of the truth of any or the correctness of any corforth in the allegations.  Accordingly, the facility has pelan of Corrections prior to response	nission that a statement of d, and is also dimission of nistrator or ther be discussed f Correction. Submission of not constitute of any kind by fasts alleged inclusions set		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	•		
		_		3956 GRAND AVENUE SOUTH			
GRAND	AVENUE REST HOMI	Ξ		MINNEAPOLIS, MN 55409			
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F 164	room.  During an interview stated she had to gher clothes. She st light on by her bed keeps her awake a no one had ever of stated, "I don't know R7 was admitted to diagnoses that includisorder, schizophi The MDS dated 1/2 cognitively intact, independent with a On 4/12/16, at 4:44 more privacy. R7 sin front of the close roommates. In addiving in the room we curtains. R7 stated moved because the R17's MDS dated 3 cognitively intact at activities of daily liver R17 stated on 4/12 enough privacy and stated there was a did not	y on 4/13/16, at 8:37 a.m., R2 go into the bathroom to change ated her roommate leaves the at night and the strong light and hurts her head. R2 stated fered her a privacy curtain and w if they would do that."  To the facility 9/30/14, with uded but not limited to mood renia, and alcohol dependency. 75/16, indicated R7 was minimally depressed and all activities of daily living.  The p.m. R7 stated she would like tated she changed her clothes at doors, because of her lition there were three people with two mobile privacy the curtains couldn't be ey fall apart.  3/27/16, indicated R17 was and independent with all ring.  2/16, at 7:02 p.m. there was not d she would like more. R17 moveable privacy screen but it vacy. Further it broke and came	F1	any dispute resolution which because of the requirement and federal law that mand of a Plan of Correction with days of the delivery of the allegations of deficiencies to participate in the program of Correction is submitted credible allegation of compart This was originally cited unthe facility was initially cert 3/31/1974, long before 3/3 is invalid. The tag was the F164. We do not believe that F460 has a implement facilities such as ours to be so we are requesting an ID Our facility is a home-like does have shared bedroof understand that we have sissues that might bother a potential resident and have that in policies and proced.  Prior to admission, we discuss the facility tour. We also concerns of the residents at the facility tour. We also concerns of the residents and the during the quarterly assessinguire and if needed addroncerns of the residents. We have moved residents facility to provide for additional signed by the resident should be a suppressed to the resident of	nts under state ate submission hin ten (10) CMS-2567 as a condition as the facility's pliance. Inder F460, but tified on that the change of that the change of that the change of the treason tation date is for the grandfathered DR.  setting and ms. We do some privacy resident or the addressed dures.  cuss privacy length during conduct a treason test of the conduct a treason that the change conduct a treason that the change conduct a treason that the		

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F 164	When the social wo about the privacy or p.m. she indicated in some rooms. The	o discuss and review privacy parterly.  orker designee was asked purtains on 4/15/16, at 3:15 they do have privacy curtains ere was no maintenance log e needed maintenance of the	F1	resident is aware the privacy screen for the specific note include roommates. We had long time." At no till screen been reque was provided to the "strong" light above bed consists of a 6-interview with reside told us that "she was roommate R12 tha "mixed up". R2 told roommates "work in reporting issues to not reported this told discussed the privation and she understandshe does not want all is well with the resident without two. There are window. There is resulted if the restriction of the privation of the cutside if the residents in the room day. If R7 chooses her closet it is her or residents in the room residents choose to of the bathrooms dispersions.  R17 shares the sai	the bedroom. A ded "I like my lave been together ime has a privacy ested. This docume survey team. The the other resider to watt bulb. During the the thing as upset" with at day and she was done with the thing and that the it out" instead of staff and that she of acy policy again with a and signed it at a privacy screen frommate.  Thas many windo dows on three side e blinds on every some requirement for desprovide privacy esidents choose to repolicy that bedrowers closed during a to change clother choice. There are the choice. There are the choice are closed to the choice. There are the choice in the shared the shared the shared	r a ment The nt's ng an S, R2 s had eith R2 gain. and ows. es, single r a r from o use om ery es by e three any in one	

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F 164	Continued From pa	ge 4	F 16	R17 does have a privacy of 7/14/15, resident requested screen and one was provid signed privacy assessment 1/6/16, and 4/18/16 that sh privacy concerns. The 4/1 document was provided to team.  It is likely the R7 and R17 at the same privacy screen th since they are roommates. reported to any staff at the survey comments mention no maintenance log available to mention that they never a Even if they had asked, sin nothing about the privacy capart, it would not be on the log.  To assure compliance with following plan has been put We discussed the privacy with R2 on 5/11/16 and she and signed the privacy asser R2 does not want a privacy is well with the roommate. The privacy policy again with 5/11/16 and she understand the privacy assessment again the privacy assessment again that the roommate. Also on SWD asked R7 if she want rooms and she declined. Find the privacy screen and there is available privacy for that be asked R17 if she wanted to and she declined. The Adri	d a privacy led. R17 has ts on 10/6/15, he has no 18/16 the survey are referring to nat "came apart". This was not facility. The that there was ole. They fail asked for one. In the thick the tinto place we knew curtain falling e maintenance this the tinto place. Poolicy again e understands essment again. If y screen and all we discussed h R7 on ds and signed ain. R7 does and all is well in 5/11/16, ted to change R17 has a so no additional ed. SWD ochange rooms	

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	` '	O PERFORM FACILITY	F 164	looked at the privacy screen in que and repaired it. We have reviewed resident's privacy assessment and have signed them with no issues. have not had any complaints to the facility.  We will continue to speak to potent residents about the privacy policy a conduct privacy assessments with residents quarterly as part of their assessment cycle. The SWD is responsible to assess resident issue this and the Administrator will monitored.	l every all We tial and all regular	5/23/16
SS=D	The resident has the services for the facifacility, if he or she documented the neplan of care; the plaservices performed voluntary or paid; contains at or above prevaring agrees to the work plan of care.  This REQUIREMENT by:	e right to refuse to perform lity; or perform services for the chooses, when the facility has ed or desire for work in the an specifies the nature of the and whether the services are empensation for paid services alling rates; and the resident arrangement described in the		Submission of this response and I	Plan of	
	review, the facility fa (R17, R13) in the sa for the facility, did s	ion, interview and document ailed to ensure 2 of 2 residents ample who performed services o according to an established I at a prevailing rate.		Submission of this response and I Correction is not a legal admission deficiency exists or that this statem deficiency was correctly cited, and not to be construed as an admission fault by the facility, the Administrate any employees, agents, or other	that a nent of is also on of	

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F 169	passing out trays for room.  R17 was interviewed R17 stated she wo kitchen passing out also stated she wat gone from 25 dollat week, because the person in the kitcher received a payched she passed out the paid cash. R17 also out on weekends. I "mad" her pay had interview with R17 stated she got paid.  The dietary managa.m. on 4/15/16, as schedule of when I the dining room. The dietary managa.m. on 4/15/16, as schedule of when I thought the resider the job only lasted.  During the survey a interview R13 hower R17's care plan daplan dated 10/20/1 either resident to hold plans for both resident was perforwhether the resider.	at 6:05 p.m. on 4/12/16, or 15 residents in the dining and at 3:27 p.m. on 4/14/16. It residents in the dining at trays to the residents. She is upset because her pay had are a week, to 15 dollars a facility had hired a new staff and when asked whether she are trays Monday-Friday and was a stated R13 passed the trays R17 again stated she was gone down. During a follow up on 4/15/16, at 10:49 a.m., R17 avery other Monday.  The was interviewed at 10:30 and produced a calendar rand R13 passed trays in the dietary manager stated she at the had volunteered and stated for ten minutes.  The manager stated she was unavailable. The care she was unavailable. The care she was getting paid for the her the resident had agreed to the resident had agreed	F 169	individuals who draft or may be dis in this Response and Plan of Correl In addition, preparation and submit this Plan of Correction does not coan admission or agreement of any the facility of the truth of any fasts or the correctness of any conclusion forth in the allegations.  Accordingly, the facility has prepar Plan of Corrections prior to resolut any dispute resolution which must because of the requirements under and federal law that mandate submof a Plan of Correction within ten (days of the delivery of the CMS-25 allegations of deficiencies as a contoparticipate in the programs. The Correction is submitted as the factedible allegation of compliance. The survey team either failed to in information regarding this deficient interview with R17 failed to establifact that the payment reduction R1 received after the dietary aide was was directly due to the job duties a spent were significantly reduced. Administrator provided information regarding a job time study and corby the dietary manager that the datactivity was 6-10 minutes per day, hour as quoted in the surveyor interview of R17. The administrator also prothe calculations for how the pay we established and that the residents effectively earning at or above minutes and the pay the residents of th	ection. ssion of institute kind by alleged ons set  ed this ion of be filed r state nission 10) 67 ndition is Plan acility's clude all cy. The sh the 7 hired and time The firmed ily not the erview ovided as were imum nissing. er was were	

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F 169	The facility's payroll 3/14/16, going forw neither resident was the facility provided for Meal Set Up dathad signed. R17 has and R13 had signed indicated the reside meal set-up, would and would follow inform lacked any incresident was being any plan for their heindividualized plans. On 4/15/16, at 4:15 designee (SWD) arinterviewed. The SV residents had come both were either pathe services render verified R17's and Farrangement, and twere not document 483.13(c)(1)(ii)-(iii), INVESTIGATE/REFALLEGATIONS/INDICTIONS/	ard and it was determined as on the facility payroll.  If forms, Resident Volunteer ed 3/11, which both residents a signed a form on 5/24/12, don 1/8/15. The information ents agreed to volunteer for be observed once a quarter, fection control guidelines. The lication as to whether either paid to perform the service, or elp having been added to their of care.  p.m. the social worker and administrator were ND acknowledged the et to her to ask for jobs and that id cash, or with gift cards, for ed in the kitchen. The SWD R13's desire to work, work the assigned kitchen duties ed on their plans of care.  (c)(2) - (4) PORT	F 16	social service. The residents are reforced and did volunteer to do this meaning that they were doing this being forced. Whether paid or no duties are the same from the dieta manager perspective. SWD provious many pages of notes that were keep the training and performance of the residents. This documentation was recommended by a previous surver line the end, the base evidence of the deficiency is because a line was meaning from a specific form.  The correction for this deficiency is discontinue the program.	work, without t, the cry ded pt on e s ey team. nis nissing	6/9/16

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F 225	or licensing authorical The facility must en involving mistreatm including injuries or misappropriation or immediately to the to other officials in through established State survey and control of the facility must have violations are thorough established by the survey and control of the facility must have a survey and control of the facility must have a survey and control of the facility must have a survey and control of the facility must have a survey and the facility must have a survey and the facility must have a survey and control of the facility must have a survey and control o	o the State nurse aide registry tities.  Insure that all alleged violations nent, neglect, or abuse, of unknown source and of resident property are reported administrator of the facility and accordance with State law of procedures (including to the ertification agency).  Insure evidence that all alleged bughly investigated, and must cential abuse while the progress.	F 22	25		
	by: Based on observareview, the facility for verbal abuse, injuring of supervision for eabuse within the far (R20, R7, R16, R15). Findings include:	NT is not met as evidenced tion, interview and document failed to report allegations of les of unknown origin, neglect elopement and substance cility for 5 of 17 residents 4, R6).		Submission of this response a Correction is not a legal admission deficiency exists or that this state deficiency was correctly cited, anot to be construed as an admifault by the facility, the Administany employees, agents, or othe individuals who draft or may be in this Response and Plan of Clin addition, preparation and sulface.	sion that a atement of and is also ission of trator or er ediscussed correction.	

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F 225	dated 2/6/16, idential activities of daily lives 8/3/15, indicated R2 substance abuse, purrently attending week. The assessmadmission has used assessment further vulnerable adult (Virelated to poor choicon the assessment facility independent A note dated 12/28, signed by the admiadmitted to having contributed to another emergency room. The was not the first times R20's progress not through 4/11/16, and a.m. R20 was found unresponsive. Emergency room. Full R20's progress not through 4/11/16, and a.m. R20 was found unresponsive. Emergency room. Full R20's mergency room. Full R20's mergency room. Full R20's mergency room. Full R20's Mental R20's for altered mental soverdose.  R20's Mental Healt through 4/5/16, indicated that R20's for altered mental soverdose.	(MDS) annual assessment fied R20 as independent with ing and intact cognition.  Safety Assessment dated 20 had an extensive history of coor decision making, and was treatment three times per nent further indicated "since dillegal drugs." The identified R20 had multiple A) issues since admission ces. Staff recommendations indicated R20 could leave the	F 2	225	this Plan of Correction does not cor an admission or agreement of any the facility of the truth of any fasts a or the correctness of any conclusion forth in the allegations. Accordingly facility has prepared this Plan of Correction prior to resolution of any dispute resolution which must be fill because of the requirements under and federal law that mandate submof a Plan of Correction within ten (1 days of the delivery of the CMS-256 allegations of deficiencies as a conto participate in the programs. This of Correction is submitted as the facredible allegation of compliance.  To assure compliance with this the following plan has been put into plathe Administrator met with OHFC management to clarify the reporting criteria for Vulnerable adult reports between federal and state requirementicident and investigation reports help been submitted to OFHC for R7, Reporting to the properties of the requirement to report these going for the workflow charts for reporting. We help have modified our vulnerable as staff in-service material to add this and address these issues. Internal reporting was done correctly in these cases, but DON and Administrator continue to monitor staff for compliance of the properting internally.  We have also recommended change the properting internally.	kind by illeged ins set of the control of the contr	

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F 225	abuse" and staff had overdose was suspontal staff and staff had overdose was suspontal staff and staff with a monitored by staff". Identified a history of heroin overdose and now had and order. Interview with the son 4/14/16 at 2:42 paware of R20's hero SWD was unaware hospitalizations due asked if R20's hero hospitalization was The SWD replied the bear ported, ever flow chart."  Interview with the irrespondent of the summary with the irrespondent of the summary with the irrespondent of the summary with R20 having and drug use prior to 2/3 drugs in the facility. Should be reported replied "I don't know R7 was admitted to diagnoses included disorder, schizophr R7's MDS quarterly 1/5/16, indicated R1 in the summary with the summary with the summary with the summary with the irrespondent of the summary with the summary wi	d an order for Narcan if ected. The mental health dicated that R20 had a verbal ther resident and resident's "needs to be closely R20's careplan dated 3/3/16, of heroin addiction-recent d indicated that the facility for Narcan.  ocial worker designee (SWD) o.m. revealed that she was oin overdose on 2/3/16. The if R20 had any other to overdose. The SWD was in overdose with reported to the state agency. The incidents were "not required to if hospitalized. We follow a sterim director of nursing at 2:28 p.m. revealed that she ing on 2/3/16, and stated she is previous drug use but was was unresponsive that I stated she was not familiar y similar incidents related to 3/16, was not aware of any When asked if this incident to the state agency the IDON	F 2	OHFC in their reporting documentation to include to clarify the confusion is federal requirements.	le this information		

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F 225	of history of chemic The care plan ident dated the care plan ident dated the care plan consumed alcohol to R7's progress notes through 4/11/16, an 9:11 p.m. R7 was founable to sit up in bwas called and R7 hospital. She return got the alcohol from R17. An emergency admission sheet dathat R7 was hospital R7's medical record appointment referrational into the alcohol intoxication that was hidden in the An interview with the 4/14/16, at 4:03 p.m familiar with R7's challed The SWD stated the problem, just becaute if it was an ongoing problem on the care administrator confirmesulting hospitalizate agency. The administrator confirmesulting hospitalizate and the care hospitalized" and the consumption of the care hospitalized" and the consumption of the care administrator confirmesulting hospitalized and the consumption of the care administrator was "not rehospitalized" and the consumption of the care administrator was "not rehospitalized" and the consumption of the care administrator was "not rehospitalized" and the consumption of the care administrator was "not rehospitalized" and the consumption of the care administrator was "not rehospitalized" and the consumption of the care administrator was "not rehospitalized" and the consumption of the care administrator was "not rehospitalized" and the consumption of the care administrator was "not rehospitalized" and the care administrator was "not rehospitalized" and the care plant was "not rehospitalized" and the	d 10/19/15, included VA issues al use making poor decisions. ified 12/28/16 (sic- facility as the year 2016) R7 that resulted in hospitalization. Is were reviewed from 10/21/15 d revealed on 12/27/15, at bund with a "blank stare led" and slurred speech. 911 was transported to the led 12/28/15. R7 reportedly in her roommates R20 and y department hospital led 12/17/15, which indicated alized for alcohol intoxication. In the led 1/11/16, which led R7 was hospitalized for leonal R7 was hospitali	F 2	25		

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F 225	p.m. revealed she incident to "where R16 was accepted 11/9/15, under condependency. The R16 was cognitively verbal behavioral so others, and rejected. The Care Area Assindicated R16 was medications for an The undated care missing person reproduced leaves of absence medications. Nursing progress of R16 was found to be resident was taken ambulance. The hold of 0.37. On 11/18/11 had been admitted R16 returned to the On 12/8/15, at 10:00 and spend the day medications through be back at 10:00 per through her boyfrie facility until 12/15/11 why she didn't returned to the some things I Mental Health Sum R16 was noncomplong history of alcodependencies, treathistory of unstable	thought the facility reported the it should be reported to."  and admitted to the facility mitment for chemical MDS dated 12/7/15, indicated by intact, mildly depressed, had symptoms directed towards d care daily.  sessment (CAA) dated 12/7/15, receiving anti-psychotic xiety and verbal aggression. plan identified R16 had one port for failure to return to time. R16 was able to have (LOA's) and self administer to the emergency room via pspital reported an alcohol level 15, it was documented that R16 to the hospital. On 11/24/15,	F 22	5		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		24E150	B. WING	·····	04	/18/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOM			STREET ADDRESS, CITY, STATE, ZIP 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 225	and medications. It that evening. On 1 called the facility to emergency room a pneumonia. The fastaff.  The IDON's hand Discharge/Summa "Consumption of a extended time with for no overnights of the consumption of a extended time with for no overnights of the consumption of a extended time with for no overnights of the consumption of a extended time with for no overnights of the consumption of the consumption of the standard of the consumption of	went on LOA with her boyfriend R16 stated she would be back 2/26/15, at 6:45 p.m. R16 or inform them she was at the and was being admitted for acility verified this with the ER written, undated any Information identified alcohol, left premises for nout notice. Broke court order outside of facility." 2 p.m. the SWD and asked for policies for resident stated the residents "Sign LOA neds." The SWD stated they amunity assessment and one of medication assessment. If a turn from the outing, she would person protocol.  overdoses were reported to the SWD stated they were "Not ported, even if hospitalized. We "the available in the facility, a conversation occurred with 15/16. The IDON had not nelopement, but she was a VA,	F 2	25		

AND PLAN OF CORRECTION   (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION   A. BUILDING				TE SURVEY MPLETED		
		24E150	B. WING _		04	/18/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP CO 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 225	identified her as a vano vulnerable adult  A review of facility procession of the state agency stated werbal aggrenot reportable to the place "frequently" be resident.  Review of facility procession of the state agency stated with the situation of the state agency stated werbal aggrenot reportable to the place "frequently" be resident.  Re's quarterly MDS and the state agency stated with the situation of the state agency stated to the place "frequently" be resident.  Re's quarterly MDS and the state agency with the situation of the state agency stated the state agency stated werbal aggrenot reportable to the place "frequently" be resident.  Re's quarterly MDS and the state agency with the state agency stated the state agency stated werbal aggrenot reportable to the place "frequently" be resident.  Re's quarterly MDS and the state agency with the state agency stated werbal aggrenot reportable to the place "frequently" be resident.  Re's quarterly MDS and the state agency with the state agency stated werbal aggrenot reportable to the place "frequently" be resident.  Re's quarterly MDS and the state agency with the state agency stated werbal aggrenot reportable to the place "frequently" be resident.  Re's quarterly MDS and the state agency with the state agency stated werbal aggrenot reportable to the place "frequently" be resident.	vulnerable adult and indicated issues.  progress notes indicated in een called a derogatory name in the facility three times that cated "this incident was very A progress note dated 4/12/16, complained of being called by another resident "qday" tated it had happened as	F 22			

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24E150	B. WING			04/1	8/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP COD 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 225	daily living except of The MDS also indice going from sitting to did not use any mobecame short of brindicated R6 had did hypertension, and smild mental retardadated 4/14/15.  R6's care plan date vulnerable adult an and 2/16/16, indicated issues. 12/23/15, to "Fx [fracture]. of profinger (etiology unk it happened)"  Observation on 4/1 R6 walking without into the smoking room. At 10 observed to stumbly smoking room.  Review of Incident/4/21/15, at 11:29 a. hours p[after] being eye all puffy and 2 staff did not know we resident did not ren/Accident report did or state agency were states agency agency agency agency agency agency agency agency agency agenc	dependent with all activities of dressing and personal hygiene. Cated R6 was unsteady when o standing or turning around, bility devices and that R6 eath with walking. R6's MDS agnoses of anemia, diabetes, achizophrenia. Diagnosis of ation noted on office visit note and 8/26/15, identified R6 as a diagnoses of anemia dated 11/16/15, ated no vulnerable adult emporary care plan problem eximal phalanx of L [left] 5th nown-res does not know how as a cane, limping and stumbling om. R6 fell into a chair in the 12:41 p.m. R6 was again e and fall into chair in the around oes not remember how it finjury listed as "hematoma, ling." Incident form indicated when injury happened and nember falling. Incident I not indicate the administrator re informed of the injury.  If Progress Notes dated	F 2	25			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24E150	B. WING _		04	/18/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOM			STREET ADDRESS, CITY, STATE, ZIP COE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409	•	, , , , , , , , , , , , , , , , , , , ,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 225	4/21/15, at 12:00 p [patient] fell agains [night], has a swol and two small lace long around eye." fell against."  Note dated 4/21/19 [complaining of] (u States hit head on to help guide her." 4/21/15 through 4/ administrator or Su unknown origin.  Nurses Record an 12/23/15, at 1:30 p office and showed noted bruising on minor swelling. R6  Physician' Progres indicated R6 was i bruising and swelli not remember hitti note indicated X-ra phalanx of left fifth orthopedic follow u recommended.  The Serious Injury the Office of the O and Mental Retard sustained an fracti hand. Description indicated "resident happened. Nurse of left hand" The s	age 16 b.m. indicated: "Appears pt st something during the noc len right eye under each eye erations are 3 mm [millimeters] "Does not remember what she because of the injury happened the injury happened the injury happened to the injury happened to the injury happened to the injury happened to the injury of the injury of the injury of the injury happened to the	F 22	25		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		24E150	B. WING		04/	/18/2016	
	PROVIDER OR SUPPLIER  AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 225	At time of the injury happened. While the was notified there wagency was notified unknown origin.  During interview on social worker design for R6 was reported but not to the state vulnerable adult issupported but not to the state vulnerable adul	- State agency] and adult nk.  7 R6 was unable to state what he Office of the Ombudsman was no evidence that the state d of the significant injury of  4/14/16, at 10:25 a.m. the nee (SWD) stated the injury d to the ombudsman's office agency because they were not nues.  4/15/16, at 9:25 a.m. licensed N)-A said "We do not the administrator. If there is a notify administrator on the because we have dealt with it. admitted to the hospital we	F 22				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		24E150	B. WING _		04	/18/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 225	been. The IDON saincidents then it is where ever we are about reporting injustate agency versus the IDON said, "I have place."  The facility's policy Maltreatment Previndicated that the faincidents are incidentally and incidents are incidentally as a second of the incidents are incidents.	know where the resident had aid, "If there have not been any not reportable. We report to supposed to." When asked uries of unknown origin to the is the office of the ombudsman ave always reported to the  entitled "Vulnerable Adult ention Plan" dated 3/6/15, acility "does not tolerate any	F 2:	25		
	of physical, verbal, form of neglect, inv punishment or mis The policy also inc -" An assessment versident prior to ad potentially dangero -"Individual suscep included in the ove with goals and app safety".	ent" which included "any form mental or sexual abuse; any voluntary seclusion, corporal handling of resident property". Indeed the following: will be made of a prospective mission for a known history of the behavior patterns" tibility will be assessed and rall resident careplan along roaches for prevention and				
	administrator must -"The administrator flowchart to determ requirements"Nursing complete whish [sic] is a coll needs to be submit Administrator submit Minnesota Departm available" -"You must make y Administrator immes safety. The facility	be notified immediately". r or representative will use the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		24E150	B. WING		04/	/18/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225 F 226 SS=E	policies and proced mistreatment, negle	P/IMPLMENT ETC POLICIES velop and implement written	F 2:			6/9/16
	by: Based on observate review, the facility for policy for reporting injuries of unknown of elopement, substor 5 of 17 residents: Findings include: The facility's policy Maltreatment Preveindicated that the fatorm of maltreatme of physical, verbal, form of neglect, inversident prior to adipotentially dangeror-"An assessment versident prior to adipotentially dangeror-"Individual susceptincluded in the overwith goals and appressifety".	ion, interview and document ailed to operationalize their of allegations of verbal abuse, origin, neglect of supervision tance abuse within the facility is (R20, R7, R16, R14, R6).  entitled "Vulnerable Adult ention Plan" dated 3/6/15, acility "does not tolerate any int" which included "any form mental or sexual abuse; any oluntary seclusion, corporal andling of resident property". Auded the following: will be made of a prospective mission for a known history of us behavior patterns" iibility will be assessed and all resident careplan along toaches for prevention and suspected or observed the		Submission of this response at Correction is not a legal admission deficiency exists or that this state deficiency was correctly cited, a not to be construed as an admifault by the facility, the Administrany employees, agents, or othe individuals who draft or may be in this Response and Plan of Cornection and subthis Plan of Correction does not an admission or agreement of a the facility of the truth of any factor the correctness of any conclusion of the allegations. According facility has prepared this Plan of Correction prior to resolution of dispute resolution which must be because of the requirements unand federal law that mandate stof a Plan of Correction within the days of the delivery of the CMS allegations of deficiencies as a to participate in the programs.	ion that a tement of and is also ssion of rator or r discussed prrection. mission of constitute any kind by its alleged asions set angly, the fany e filed ider state abmission in (10) -2567 condition This Plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24E150	B. WING			04/-	18/2016
-	PROVIDER OR SUPPLIER  AVENUE REST HOME	<u> </u>		39	REET ADDRESS, CITY, STATE, ZIP CODE 56 GRAND AVENUE SOUTH NNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	administrator must -"The administrator flowchart to determ requirements"Nursing complete whish [sic] is a colle needs to be submit Administrator subm Minnesota Departn available" -"You must make y Administrator imme safety. The facility reportable incidents MDH".  R20 was admitted minimum data set of dated 2/6/16 identifiactivities of daily live R20's Community 8 8/3/15 indicated the history of substanc making, and was of three times per we indicated "since ad drugs". The assess had multiple vulner admission related to recommendations of R20 could leave the A note dated 12/28 signed by the admin admitted to having contributed to anote emergency room.	be notified immediately".	F 2	26	credible allegation of compliance.  To assure compliance with this the following plan has been put into plath administrator met with OHFC management to clarify the reporting criteria for Vulnerable adult reports between federal and state requirent Incident and investigation reports heen submitted to OFHC for R7, R20.  We have updated our reporting polworkflow charts for reporting. We begun retraining the staff on the requirement to report these going for We have modified our vulnerable a staff in-service material to add this and address these issues. Internating reporting was done correctly in the cases, but DON and Administrator continue to monitor staff for complimenting internally.  We have also recommended changous of the confusion between staff dederal requirements.	nents. ave 16, and icy and have orward. dult clarity se will ance in ges to	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONST	(X3) DATE SURVEY COMPLETED			
		24E150	B. WING			04/	/18/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME	:		3956 GRA	DDRESS, CITY, STATE, ZIP CODE  ND AVENUE SOUTH  POLIS, MN 55409	, <u>, , , , , , , , , , , , , , , , , , </u>	.6/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT EACH CORRECTIVE ACTION SHOU OSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 226	R20's progress not 1/16-4/11/16 and re R20 was found to be Emergency Medical activated, the residu (medication which it such as Heroin) and emergency room. Feed Hospital Discharge indicated that R20 is for altered mental soverdose.  R20's Mental Healt 3/5/16-4/5/16 indicated that R20 is for altered mental soverdose.  R20's Mental Healt 3/5/16-4/5/16 indicated that R20 is for altered mental soverdose was suspsummary further industrication with another family member and monitored by staff". identified a history of heroin overdose annow had and order.  Interview with the Son 4/14/16 at 2:42 gaware of R20's herospitalizations due asked if R20's herospitalization was The SWD replied the tobe reported, every flow chart".	es were reviewed from evealed on 2/3/16 at 7:30 a.m. e lethargic and unresponsive. I Services (EMS) were ent was provided Narcan everses some overdoses d transported to the R20 was admitted. R20's Summary dated 2/8/16 was admitted to the hospital tatus and accidental heroin the Summary dated at lengthy use and methamphetamine d an order for Narcan if ected. The mental health dicated that R20 had a verbal ther resident and resident's "needs to be closely R20's careplan dated 3/3/16 of heroin addiction-recent d indicated that the facility for Narcan.  Social Worker Designee (SWD) o.m. revealed that she was oin overdose on 2/3/16. The if R20 had any other et to overdose. The SWD was	F 2	26			

-	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		DATE SURVEY COMPLETED
		24E150	B. WING			04/18/2016
-	PROVIDER OR SUPPLIER  AVENUE REST HOME		,	STREET ADDRESS, CITY, STATE, ZIP 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 226	(IDON) on 4/15/16 was the nurse work was aware of R20's unaware why R20 worning. The IDON with R20 having an drug use prior to 2/drugs in the facility. should be reported replied "I don't know R7 was admitted to diagnoses that includisorder, schizophr R7's Minimum Data assessment dated was intact and was daily living.  R7's careplan dated was intact and was daily living.  R7's careplan dated adult (VA) issues of behavior and chem decisions. The care facility dated the care consumed alcohol mass called and R7 hospital. She return got the alcohol from R17. An emergency admission sheet dathat R7 was hospital. R7's social service	at 2:28 p.m. revealed that she king on 2/3/16 and stated she is previous drug use but was was unresponsive that I stated she was not familiar y similar incidents related to 3/16 was not aware of any When asked if this incident to the state agency the DON		226		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24E150	B. WING		04	/18/2016	
_	PROVIDER OR SUPPLIER  AVENUE REST HOME	:		STREET ADDRESS, CITY, STATE, ZIP ( 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 226	worker designee (Sthe drinking incider R7 got angry and s R7's medical record appointment referrational included the note that designed that was hidden in the substantial was hidden in the substantial was hidden in the substantial was an ongoing problem, just becaute it was an ongoing problem on the card administrator confirment of the substantial was "not referre with the substantial was an ongoing problem on the care administrator confirment was "not referre with the substantial wa	WD) spoke with R7 regarding at and resulting hospitalization. Creamed "that was not me."  d included a psych al dated 1/11/16, which that R7 was hospitalized for a Roommate gave her alcohol the room.  The SWD and administrator on the indicated the SWD was the mical dependency issues. The electron are something happens once, issue I would have put it as a replan". The SWD and the alcohol use and the administrator stated the required to be reported to the administrator stated the required to the reported, even if that the facility followed a flow of incidents to the state.	F 2	26			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		24E150	B. WING		04	/18/2016	
	PROVIDER OR SUPPLIER  AVENUE REST HOMI			STREET ADDRESS, CITY, STATE, ZIP CODE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 226	The undated care missing person repfacility at specified leaves of absence medications.  Nursing progress of R16 was found to be resident was taken ambulance. The hoof 0.37. On 11/18/1 had been admitted R16 returned to the On 12/8/15, at 10:0 and spend the day medications through be back at 10:00 p through her boyfrie facility until 12/15/1 why she didn't returned some things I Mental Health Sum R16 was noncomplong history of alco dependencies, treat history of unstable getting alcohol from favors.  On 12/25/15, R16 of and medications. Find the facility to emergency room a pneumonia. The fastaff.  The interim director written, undated Director identified "Consum identified "Consum identified" Consum identif	xiety and verbal aggression. plan identified R16 had one port for failure to return to time. R16 was able to have (LOA's) and self administer notes on 11/17/15, at 6:00 p.m. be lethargic and confused. The to the emergency room via pospital reported an alcohol level 5, it was documented that R16 to the hospital. On 11/24/15,	F 22				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		24E150	B. WING		04	/18/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409	-	, 13, 2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 226	On 4/14/16, at 2:42 (SWD) and administration resident LOA's residents "Sign LOTHE SWD stated the assessment and or medication assess return from the outmissing person prowhen asked if the the state agency, the required to be reported to be report	ghts outside of facility."  2 p.m. the social work designee strator were asked for policies. The SWD stated the DA form and ask for meds." hey complete one community he self administration of ment. If a resident did not ing, she would utilize the stocol.  Overdoses were reported to he SWD stated they were "Not writed, even if hospitalized. We "available in the facility, a conversation occurred with 15/16. The IDON had not elopement, but she was a AA), "I thought it was reported." A report R16's alcohol SA. The facility also failed to cont from 12/8-12/15/15 to the effecility reported it so the effect and was independent daily living. R14's care plan tified her as a vulnerable adult ulnerable adult issues.  Orogress notes indicated in the facility three times that icated "this incident was very A progress note dated 4/12/16 complained of being called by another resident "qday" tated it had happened as	F 22	6			

24E150 B. WING 04/18/20	(X3) DATE SURVEY COMPLETED	
	3/2016	
NAME OF PROVIDER OR SUPPLIER  GRAND AVENUE REST HOME  STREET ADDRESS, CITY, STATE, ZIP CODE  3956 GRAND AVENUE SOUTH  MINNEAPOLIS, MN 55409		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	(X5) COMPLETION DATE	
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," 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 hyglene. 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 schizopheraia. Diagnosis of mild mental retardation noted on office visit note dated 4/14/15.		

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	PROVIDER OR SUPPLIER  AVENUE REST HOM			STREET ADDRESS, CITY, STATE, ZIP COD 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		
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F 226	R6's care plan date vulnerable adult ar and 2/16/16, indic issues. 12/23/15, to "Fx [fracture]. of pr finger (etiology unkit happened)"  Observation on 4/1 R6 walking without into the smoking rosmoking room. At observed to stumb smoking room.  Review of Incident 4/21/15, at 11:29 a hours p[after] being eye all puffy and 2 R [right] eye. She of happened." Type of abrasion, and swe staff did not know resident did not rerifaccident report did or state agency we Nurses Record and 4/21/15, at 12:00 p[patient] fell agains [night], has a swoll and two small lace long around eye." In the state of the swoll and two small lace long around eye." In the swoll against."	age 27 ed 8/26/15, identified R6 as a and comments dated 11/16/15, ated no vulnerable adult emporary care plan problem oximal phalanx of L [left] 5th known-res does not know how a 3/16, at 11:40 a.m. identified a cane, limping and stumbling from. R6 fell into a chair in the 12:41 p.m. R6 was again le and fall into chair in the 12:41 p.m. R6 was again le and fall into chair in the man indicated "Pt woke up-few g up we noticed her R [right] sm [small] lacerations around does not remember how it if injury listed as "hematoma, lling." Incident form indicated when injury happened and member falling. Incident do not indicate the administrator are informed of the injury.  Independent of the injury of the injury.  Independent of the injury of the injury of the injury.  Independent of the injury of	F 2	26		

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F 226	administrator or SA unknown origin.  Nurses Record and 12/23/15 at 1:30 p.r office and showed in noted bruising on the minor swelling. R6  Physician's Progressindicated R6 is in control of the control	Progress Notes dated m. indicated R6 came into nurse her left hand. Nurse he front and back of hand with was sent to urgent care.  So Notes dated 12/23/15, linic for assessment of ag of left hand and that R6 did ag hand or banging it. Progress y showed fracture of proximal finger splint placed and to with in next week  Report dated 12/23/15, sent to mbudsman for Mental Health ation, indicated R6 had re of the fifth finger of the left of how the injury happened does not know what bserved swelling and bruising ection triggering others to be edical, OHFC [Office of Health - state agency] and adult nk.  4/15/16, at 9:25 a.m. hurse (LPN)-A said "We do not the administrator. If there is a notify administrator on the because we have dealt with it. admitted to the hospital we	F 22			

	OF DEFICIENCIES OF CORRECTION				E SURVEY IPLETED	
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F 280 SS=E	During interview on SWD said "I don't the administrator be adult issue, it was a would need to know vulnerable adult issue being beaten. Do not fall."  During interview on administrator said, me. I expect them  During interview on interim director of not facility reported inju Reporting fractures we know where the said, "If there have is not reportable. We supposed to." Whe injuries of unknown versus the office of said, "I have always 483.20(d)(3), 483.1 PARTICIPATE PLA  The resident has the incompetent or othe incapacitated under participate in plannic changes in care and A comprehensive comprehensive assets."	4/15/16, at 9:27 a.m. the hink they would bother calling ecause it was not a vulnerable a serious injury. [Administrator] v about fractures if it were a ue like the fracture was due to ot need to know if it is due to a 4/15/16, at 2:15 p.m. the "I ask them to chart notifying to notify me about fractures."  4/15/16, at 2:19 p.m. the surses (IDON) stated, the urses (IDON) stated, the urses of unknown origin. depended on whether or not resident had been. The IDON not been any incidents then it be report to where ever we are en asked about reporting a origin to the state agency the ombudsman the IDON is reported to the same place."  0(k)(2) RIGHT TO NNING CARE-REVISE CP are right, unless adjudged erwise found to be the laws of the State, to ing care and treatment or	F 22			6/10/16

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F 280	disciplines as deter and, to the extent p the resident, the re- legal representative	ige 30 d other appropriate staff in mined by the resident's needs, tracticable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after	F 2	80		
	by: Based on observareview, the facility findividual resident of accidents, and/or stresidents (R20, R7) Findings include: R20 was admitted annual Minimum Didated 2/6/16, indicated the poor decisions, had and was currently aper week. The ass R20 had a history of "former heroin addiadmission has used assessment further multiple VA (vulnera admission related the recommendations of the same assessment of the same accommendations of the same accommendation of the sam	tion, interview, and document ailed to update/revise care plans related to ubstance abuse for 4 of 18, R16, R6).  To the facility on 3/23/15. An ata Set (MDS) assessment ated R20 was independent with ing and had intact cognition.  Safety Assessment dated at R20 had a history of making of chemical dependency issues attending treatment three times ressment further indicated that of substance abuse and was a ct" and indicated, "since dillegal drugs." The indicated that R20 had able adult) issues since o poor choices. However, staff on the assessment indicated that affor the assessment indicated the facility independently.		Submission of this response Correction is not a legal adm deficiency exists or that this deficiency was correctly cited not to be construed as an adfault by the facility, the Admir any employees, agents, or or individuals who draft or may in this Response and Plan of In addition, preparation and sthis Plan of Correction does an admission or agreement of the facility of the truth of any or the correctness of any corforth in the allegations.  Accordingly, the facility has performed to the course of the requirements and federal law that mandate of a Plan of Correction within days of the delivery of the Challegations of deficiencies as to participate in the programs of Correction is submitted as credible allegation of complia	sission that a statement of d, and is also Imission of histrator or ther be discussed f Correction. Submission of not constitute of any kind by fasts alleged inclusions set or epared this esolution of must be filed a under state e submission in ten (10) MS-2567 is a condition is the facility is statement of the facility is statement	

AND BLAN OF CORRECTION INDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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GRAND	AVENUE REST HOM	E		3956 GRAND AVENUE SOUTH		
•		_		MINNEAPOLIS, MN 55409		
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F 280	R20's careplan da of heroin addictior indicated that the for possible heroir further indicated the signs and sympton hospitalization on initiation of off-site indicated on carepidentify intervention methamphetamine the recent THC lal.  A note dated 12/2 signed by the admadmitted to having contributed to ano emergency room. was not the first tinfurther stated that required to ensure residents.  Interview with the (SWD) on 4/14/16 aware of R20's he SWD was unawar hospitalizations duaware of R20's pahad tested positive confirmed that this careplan. The SW drugs or alcohol in treatment for past attended as order alcohol in her roor room, R7 consum confirmed that R7	ted 3/3/16, identified a history in-recent heroin overdose and facility now had Narcan orders in overdose. The careplan hat staff were to monitor for ms of drug overdose. R20 2/3/16, for heroin overdose and it treatment on 2/29/16, was olan. The care plan failed to his for the use of e use, ongoing alcohol use, or	F 28	To assure compliance with the following plan has been put in R16 has been discharged. For process of discharge we are a suitable discharge location address all her needs. R6 saw a physician on 5/2/16 orthopedic surgeon 5/5/16. It that visit was to receive cortist her left knee to improve her gosteoarthritis and will follow a months for review. The Mediand Consulting Pharmacist record and medications on 5/2 Medical Director did not addinterventions but recomment physical therapy or we considuscharging to a higher level Consulting Pharmacist wrote medication change recomment the physician. R6 agreed to attending PT so she can stay facility. A new fall assessment started.  R7 has been stable before the and since. We do believe the interventions that we have in sufficient given the resident whistory.  Actions taken to identify othe residents having similar occur have reviewed other resident for history of addictive behaving updated the community asse care plan interventions for eanecessary.  We will continue to screen reincrease our research on issue.	nto place. 120 is in the e looking for that can  and The result of sone shots in gait due to up every four ical Director eviewed R6 (19/16. The any led R6 beginder of care. The one endation to start in our int was the incident at the place are vishes and repotential rrences. We diagnoses for and assments and ach as sidents and	

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F 280	incident with R20. Inot aware of R20's when asked if alcohol use care plan the SWD want me to do. I carules you have to leany program, I don people."  R7 was admitted to diagnoses that includisorder, schizophr R7's Minimum Data assessment dated cognition was intacactivities of daily liv R7's careplan dated vulnerable adult iss behavior and chem decisions. Interver Inservice and educ did not identify any risk of alcohol use imonitoring for use.  R7's progress note revealed R7 was fot o sit up in bed" and asked R7 if she had not answer. 911 was emergency room a emergency departed dated 12/17/15 indifor alcohol intoxical Interview with the s	The SWD stated that she was alcohol use in the facility and not use or interventions to a were addressed on R20's stated "I don't know what you in say if you don't follow the eave. She is not committed to it have any leverage on these of the facility on 9/30/14, with uded but not limited to mood enia, and alcohol dependency. A Set (MDS) quarterly review 1/5/16, indicated R7's the and was independent with ing.  If 10/19/15, included use of history of promiscuous ical use/making poor utions included invite to yearly attended to minimize the nocluding supervising and she did as called. R7 was taken to the not returned on 12/28/15. An ment hospital admission sheet cated that R7 was hospitalized	F 2	and chemical addictions SWD will continue to quare within the scope of a home.  The Administrator will maintaining compliance decision process for new	alify residents that a Board and Care conitor that we by assisting in the		

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F 280	alcohol issues and SWD stated that should received naltrexon alcohol searches and alcohol searches and checks once per whom the care plan and state addressed in R7's "not a problem, just once, if it was an outrout it was a problem on R16 was accepted 11/9/15, under condependency. The Minimum Data indicated R16 was depressed, had we directed towards on R16 was independent and had a diabetic. The Care Area Assindicated R16 was medications for an aggression. In add dependency issues repeated falls and The undated care alcohol intoxication homelessness. The three times weekly would not drink. Apapointments and resident bags if outbags when coming needed, case man intoxicated, notify for received naltrexon.	SWD was familiar with R7's dependency issues. The ne was unaware the R7's ohol. The SWD stated that are completed with room eek. The SWD completed R7's ed that alcohol use was careplan the alcohol use was to because something happens ngoing issue I would have put the careplan".  and admitted to the facility on amitment for chemical a Set (MDS) dated 12/7/15, cognitively intact, mildly roal behavioral symptoms thers, and rejected care daily. eet with activities of daily living, diet. sessment (CAA) dated 12/7/15, receiving anti-psychotic xiety and she had verbal ition to the extensive chemical s, R16 had a history of	F 28			

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F 280	return to facility at a also indicated R16 medications. Physicians Progres identified a recent I intoxication with ref Physicians Progres do toxicology screed Mental Health Sum R16 was noncomplong history of alco dependency treatmentstory of unstable and recent hospital alcohol intoxication supplying her with a Physicians Progres identified R16 contialcohol-concealed On 4/14/16, at 2:42 designee) stated we drinking, she had consearched R16 's responsible to the searched R16 's responsible to the searched R16 in the SW once a week and a The facility's policy Maltreatment Preventicluded:  "An assessment wire resident prior to ad potentially dangero "Individual susception included in the overwith goals and apposafety. The careplastic included in the core with goals and apposafety. The careplastic included in the careplastic included	ing person report for failure to specified time. The care plan was able to self administer as Notes dated 11/25/15, hospitalization due to alcohol turn 11/24/15. It is Notes dated 12/2/15, Ok to en at facility discretion. Imary dated 12/9/15, indicated liant with medications, had a hol use and multiple chemical tent programs and a long housing. Continued to drink dization 11/17-11/24 due to a R16 had a boyfriend that was alcohol for favors. Is Notes dated 12/31/15, inued to consume it in a bottle of crystal light. It in a bottle of crystal light. It is pom, and searched her D stated staff would search	F 28			

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F 280	"Careplan's included of aggressive behas self-injurious behave R6's quarterly Minit 2/5/16, indicated R6 was independent wexcept dressing an also indicated R6 we sitting to standing of any mobility device breath with walking diagnoses of anemediagnoses of anemedia	information regarding history viors, wandering or	F 28			

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F 280	walking from the dibathroom, just off thalting gait stumbling R6 was not using a During random observed wand stumbling into a chair in the smok was again observed chair in smoking room Review of Nurses' (PN) from 7/2/15. Upon 7/23/15, 11/25/1 was no evidence thappropriate intervel During interview on director of nurses (investigated and cainterventions identifications).	p.m. R6 was observed ning room table to the he living room. R6 had a ng and reaching for furniture. ny device.  Pervation 4/13/16, at 11:40 a.m. walking without a cane, limping the smoking room. R6 fell into ing room. At 12:41 p.m. R6 d to stumble and fall into a om.  Record and Progress Notes antil 4/13/16, indicated R6 fell 5, 1/4/16, and 2/22/16. There he care plan was updated with antions following multiple falls.  14/15/16, at 2:19 p.m. interim IDON) said, "All falls are are planned with new fied."	F 28	30		
F 315 SS=D	10/29/15, identified the care plan with r reviews.	Planning policy updated it lacked direction for updating new issues between MDS HETER, PREVENT UTI, ER	F 31	5		6/9/16
	assessment, the fa resident who enters indwelling catheter resident's clinical or catheterization was	ent's comprehensive cility must ensure that a s the facility without an is not catheterized unless the ondition demonstrates that a necessary; and a resident of bladder receives appropriate				

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F 315	treatment and servinfections and to refunction as possible  This REQUIREMEL by: Based on observa	ices to prevent urinary tract store as much normal bladder e.  NT is not met as evidenced tion, interview and document	F3	Submission of this respons			
	review, the facility of reassess, identify a provide assistance residents (R6) review Findings include:  R6's quarterly Minit 2/5/16, indicated Rexperienced incontrequiring assistance However, the MDS become continent of R6's diagnoses income and incontinence. A 2/11/16, indicated Finocturia. R6's care R6 experienced unifrequency to toilet, incontinence with soiled slacks and up in a laundry basket assistance was producing an interview During an interview	ailed to comprehensively appropriate interventions and with toileting, for 1 of 1 ewed for incontinence.  mum Data Set (MDS) dated 6 was cognitively intact, and inence of bowel and bladder e with personal hygiene. further indicated R6 had with staff assistance at night. luded developmental delays A bladder assessment dated R6 had urinary frequency and plan dated 2/11/16, indicated nary incontinence with and indicated R6 had no cheduled toileting at night.  sion on 4/12/16, at 5:28 p.m. o independently remove urine inderclothing and placed them in her room. No staff ovided to R6 at that time.		Correction is not a legal addeficiency exists or that this deficiency was correctly cited not to be construed as an afault by the facility, the Admany employees, agents, or individuals who draft or may in this Response and Pland In addition, preparation and this Plan of Correction does an admission or agreement the facility of the truth of an or the correctness of any conforth in the allegations.  Accordingly, the facility has Plan of Corrections prior to any dispute resolution which because of the requirement and federal law that mandate of a Plan of Correction with days of the delivery of the Callegations of deficiencies at to participate in the program of Correction is submitted a credible allegation of compliance with incorrect and we are requesting the compliance with	mission that a statement of ed, and is also admission of inistrator or other by be discussed of Correction. I submission of a not constitute to fany kind by y fasts alleged onclusions set prepared this resolution of h must be filed to under state te submission in ten (10) CMS-2567 as a condition ns. This Plan as the facility sliance. This plan is the facility sliance.		
		ed incontinence if she was out		following plan has been put We have interviewed R6 ar	into place.		

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	PROVIDER OR SUPPLIER  AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP CO 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409	•		
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F 315	housekeeper (HK)-laundry and stated soiled. HK-A stated herself appropriate  During an interview licensed practical mincontinence was "still had incontinence R6's care plan appropriate approaches for help continence during the encourage/assist approaches for help continence of the encourage and incontinent on several years she in hight. The DON states been fairly under complan had not been in assistance with help incontinence.  There was no current accurately reflected and needs for toiled located in her record 483.25(h) FREE OF HAZARDS/SUPER.	on 4/15/16, at 8:21 a.m., A stated she did the residents' R6's underclothes were often d, "I don't think [R6] cleans y."  on 4/15/16, at 8:29 a.m. urse (LPN)-A stated R6's up and down" and verified R6 be at times. LPN-A verified roach stating, "We wake her ing, but not during the day." ad not been revised to include bing R6 improve her he day, nor to 6 with personal hygiene nce.  on 4/15/16, at 2:08 p.m. the hursing (IDON) stated R6 had wer the years but stated the last had been incontinent mostly at ted R6's incontinence "has bontrol." Therefore, her care revised to include regular ping R6 manage the  ent assessment which I R6's pattern for continence, ing and grooming assistance d.  EACCIDENT	F 31	being completely continent. urologist and had a medical completed to 5/17/16 to help decrease urgency. Our new completed a new bladder as R6. The results were that the continent with the existing out toileting plan.  Actions taken to identify other residents having similar occurs as part of their medical reconserviewed the bladder assess other residents and have defined the conserviewed the bladder assess other residents and have defined the head of the pladder assess of the residents and have defined the bladder assessment form determined that no changes Nursing will continue to mon incontinence and notify the Enthere is a change in status a chart in the resident medical DON will continue to comple assessments upon admission or more often as needed. The continue to take actions as nowhen changes in a bladder a warranted. We have added monitoring to the weekly DO The Administrator will monit compliance by monitoring the DON checklist.	procedure R6 to help v DON sessment on re resident is vernight  er potential urrences. assessment rd. We have sments for all termined that  nittee, or, reviewed n and are needed. itor DON when s well as record. The te bladder on, quarterly, he DON will necessary assessment is incontinence N checklist. or to maintain	6/9/16	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		24E150	B. WING		04/18/2016	
	PROVIDER OR SUPPLIER  AVENUE REST HOME		3	STREET ADDRESS, CITY, STATE, ZIP CODE 1956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409	0 11 101 20 10	
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F 323		ge 39 each resident receives on and assistance devices to	F 323			
	by: Based on observatoreview, the facility finterventions to prefor 4 of 4 residents for accidents.  Findings include: R20 was admitted to annual minimum dated 2/6/16, identificativities of daily lived by the facility of the facility. The plan to minimize safe of the facility. In addeveloped a plan were for the facility of the facility of the facility of the facility of the facility.	ion, interview and document ailed to supervise and provide vent injury and hospitalizations (R20, R7, R16, R6) reviewed  to the facility on 3/23/15. An ata set (MDS) assessment fied R20 as independent with ing and intact cognition.  Safety Assessment dated 20 had a history of making emical dependency issues and ding treatment three times per nent further indicated that R20 ostance abuse and was a ct" and that "since admission igs". The assessment also made multiple poor choices. In the many propriate interventions to the R20 obtaining and using the R20 obtaining the R20		Submission of this response and Pl Correction is not a legal admission to deficiency exists or that this statemed deficiency was correctly cited, and is not to be construed as an admission fault by the facility, the Administrator any employees, agents, or other individuals who draft or may be discoin this Response and Plan of Correction addition, preparation and submission this Plan of Correction does not come an admission or agreement of any kethe facility of the truth of any fasts at or the correctness of any conclusion forth in the allegations.  Accordingly, the facility has prepared Plan of Corrections prior to resolution any dispute resolution which must be because of the requirements under and federal law that mandate submit of a Plan of Correction within ten (10 days of the delivery of the CMS-256 allegations of deficiencies as a concept to participate in the programs. This of Correction is submitted as the factoredible allegation of compliance.	that a ent of s also of or or ussed etion. Sion of stitute aind by lleged as set of this en of e filed state ssion 0) 7 dition s Plan	
		R20 obtaining and using al drugs in the facility.		To assure compliance with this the following plan has been put into place	ce. R6	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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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		F3	saw a physician on 5/2/16 and surgeon 5/5/16. The result of the was to receive cortisone shots knee to improve her gait due to	nat visit		
	contributed to ano emergency room. the first time this had violation of the fact stated that addition to ensure the safe residents and sugsubject to random change. R20's maprevious dates or R20's progress no	ther resident (R7) going to the The note indicated this was not ad occurred and that this was a ility policy. The note further nal interventions were required ty of R20 and the other gested that R20 was now room checks and a room edical record did not identify incidents related to alcohol use.		osteoarthritis and will follow up months for review. R6, R7, and specifically reviewed at the QA 5/19/16. R6 was recommended physical therapy to improve her had previous refused, but after the seriousness of this need for has now agreed to attend. R7 stable before the incident and shas been discharged. R20's call and community assessment has updated.	R20 were meeting on a for gait. She explaining PT, she has been ince. R16 re plan		
	although able to re Given 5 ounces of so thirsty". One ha couldn't eat breakt stomach". R20 wa was called by roor worried" about R2 across bed with he	n. resident appeared lethargic espond to questions if asked. apple juice and stated "I'm just alf hour later R20 states she fast and "felt sick to her is checked again after the nurse mmates stating they "were 0. Nurse found resident "laying ead and neck hyperextended. eathing, pulse approx [sic]		Actions taken to identify other presidents having similar occurre have reviewed other resident difor history of addictive behavior updated the community assess care plan interventions for each necessary.  We will continue to screen residence our research on issue and chemical addictions. The SWD will continue to qualify residence.	ences. We agnoses and will ments and as lents and of alcohol DON and		
	responsive-pupils attendants gave N drugs like heroin) taken to ER". Phys 2/3/16, a "Postnot entry that indicated found a suicide not reported any s	dilated. 911 was called- larcan (a medication to reverse and resident responded and sician and family notified.  e" was written below the above d that "EMTS [sic] state they are and took it with them. Res. uicidal thoughts to this nurse on the sice of the state		are within the scope of a Board home. We do screen and have accepted four potential resident past six months. We have ret nursing staff on the importance orthostatic pressures and have our Fall Scene Investigation repinclude more details on reporting in orthostatic blood pressures a followup required before the co	and Care not s in the rained the of the updated ort to g of drops nd the		

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F 323	resident admitted for 2/3/15, at 5:00 p.m.  There was no follow information regarding medical record.  R20's Hospital Discindicated that R20's for altered mental soverdose.  Review of R20's Midischarge summary 1/9/16. In addition a was completed on When asked for the summary and docut the hospital did not summary. Licensed stated "We only ne shred the rest."  R20's Mental Healt 3/5/16-4/5/16, indichistory of heroin ababuse" and staff has (reverses an overdoverdose was suspsummary further in altercation with and family member and monitored by staff".  R20's careplan dato of heroin addiction-	or snorting heroin".  R20 admitted to hospital  y up documentation to the ng R20's suicide note in R20's  charge Summary dated 2/8/16, was admitted to the hospital status and accidental heroin  DS assessments indicated a y was also completed on an entry tracking record MDS 1/13/16.  1/9/16 hospital discharge mentation, the SWD stated provide them with any written d practical nurse (LPN-A) ed the medication list, we  h Summary dated ated that R20 had a "lengthy use and methamphetamine d an order for Narcan ose for some medications) if vected. The mental health dicated that R20 had a verbal other resident and resident's  l'needs to be closely	F 323	the form. We have a new DON in and she will be reviewing each ne form for completion, correctness a followup.  The DON will implement these chand the Administrator will monitor maintaining compliance by review Fall Scene Investigation reports d QA meetings.	w fall and anges that we ing the	

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	further indicated sta and symptoms of continuous dentification of off-site identified on the call identified on the call identified the reside issues this past qualidentify concerns with R20's labs were residentify concerns with R20 tested positive 3/26/16. R20's mediany further follow under the follow under th	overdose. The careplan aff was to monitor for signs rug overdose. R20's r/3/16, for heroin overdose and treatment on 2/29/16, was replan. R20's careplan further ent had no vulnerable adult arter. The careplan did not rith alcohol possession or use. Viewed which indicated that for THC (marijuana) on dical record did not indicate p with the positive lab result.  Red on 4/14/16, at 3:15 p.m. and not write a suicide note, that it her boyfriend who had R20 also confirmed that she ohol as a gift. R20, R16 and s and when she and R16 left and "gotten into it" and whole bottle". R20 stated that cted the nurse when they and R7 was intoxicated and R20 also stated she had roin laced with Fentanyl, just	F 323				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	24E150	B. WING		04/	18/2016	
NAME OF PROVIDER OR SUPPLI			STREET ADDRESS, CITY, STATE, ZIP CODE 8956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409	,		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
who stated she "aware of R20's phad tested positic confirmed this was careplan. The Stor alcohol in the was in treatment she attended as had alcohol in the the room, R7 consward successful confirmed alcohol intoxication incident with R20 R20 did not have upon her hospital roommates". The allowed in the falcohol use or in use were addresstated "I don't know can say if you do leave. She is not don't have any leave. The long is previou unaware why R2 morning. The ID familiar with R20 related to drug uwas not aware of IDON stated she	e discussed the incident with R20 wanted to live". The SWD was ast drug use and stated that R20 ve for marijuana once before and as not indicated on R20's WD stated there were no drugs facility. She further stated R20 for past drug addiction, which ordered. The SWD stated R20 er room and when R20 had left insumed the whole bottle. The R7 was hospitalized due to on and she had discussed the D. The SWD went on to say that a room change as R7 stated I return that she "loved her is SWD stated that alcohol is not cility. She was not aware of R20's in ferventions to prevent alcohol sed on R20's care plan the SWD ow what you want me to do. I in't follow the rules you have to committed to any program, I inverage on these people."  Interim Director of Nursing a fat 2:28 p.m. revealed she was g on 2/3/16, and she was aware is drug use. The IDON was 0 was unresponsive that DN stated that she was not having any similar incidents see prior to 2/3/16. Further, she fany drugs in the facility. The did not observe a suicide note (3/16, and was only aware of the	F 323				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 323	actually a "love letter IDON stated this infollowed up in R20's R7 was admitted to diagnoses that inclus chizophrenia, and R7's careplan dated vulnerable adult iss behavior. Chemical The care plan ident dated the care plan alcohol that resulter favorable. Not a typ 1/11/16 and 4/11/16 identified. R7's care appropriate interver or monitoring R7 for R7's progress notes 10/21/15-4/11/16 and 12/27/15 at 9:11 p.r a call from [R7]'s si the phone with [R7] The nurse went to I "blank stare unable speech. The nurse drinking and she did 12/27/15 at 9:20 p.1 "unable to stand an was slurred and she floor by paramedics"	d found out the note was er" and not a suicide note. The formation should have been is medical record.  The facility on 9/30/14, with uded mood disorder, alcohol dependency.  d 10/19/15, included the ues of "hx of promiscuous use making poor decisions". iffied "12/28/16 (sic-facility as the year 2016) consumed d in hospitalization Prognosis ical behavior". For the dates is "No VA issues" were en plan did not identify intions to minimize alcohol use or incidents of use.  Is were reviewed from the nurse received ster who stated she was on and her speech was slurred. R7's room and found R7 with a to sit up in bed" with slurred asked R7 if she had been d not answer. 911 was called.  The substitute of the nurse received ster who stated she was on and her speech was slurred. R7's room and found R7 with a to sit up in bed" with slurred and R7 was a to sit up in bed work of the nurse received she was carried down to the first ster. R7 was transported to the nurse received to the nurse received ster. R7's family notified and	F 32	3		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	:		STREET ADDRESS, CITY, STATE, ZIP CODE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG			ID PREFI TAG	PROVIDER'S PLAN OF CORREC  X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 323	R17) came to nurse drank 24 ounces of room when they we returned the 24 our Administrator notified 12/27/15 at 9:40 p.r. room (E.R.) on R7's 12/28/15 at 3:20 p.r. hospital via transpoon No further incidents in R7's progress no however, an emergadmission sheet dawas hospitalized for R7's social service following:  1/4/16, writer spoked drinking incident and upset and starting swas not me". Reside and writer did not continued the service following:  1/11/16, care confered that 1 hospitalization poisoning-liquor was roommate. Resider incident along with past quarter.  R7's medical record appointment referrational ded the note the service of the s	m. R7's roommates (R20, e and informed that R7 had Vodka that they left in the ent out to smoke. When they nee bottle of Vodka was empty. ed.  m. nurse updated emergency is consumption of alcohol.  m. R7 returned from the ent.  s of alcohol use were identified thes or medical record. ency department hospital ency department hospital ency department into alcohol intoxication.  progress notes identified the ent.  with resident regarding department of the ent.  with resident regarding ent.  ent.  ent.  ent.  ent.	F3	923			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 323	alcohol level was > An interview with the 4/14/16 at 4:03 p.n familiar with R7's at The SWD stated seroommate had alcoin the house. The SWD confirms of room checks and residents that were completed R7's can was addressed in land and a problem, just once, if it was an oit as a problem on she discussed the declined treatment again and she be informed R7's room ont have alcohol in to other residents.  An interview with the (IDON) on 4/15/16 aware of R7's alcohospitalization. How day the incident of the undated facilit Rules and Responsible beverages were all approval from the pwere allowed in the R16 was admitted.	ne SWD and administrator on in. indicated the SWD was alcohol and dependency issues, he was unaware R7's ohol. Alcohol was not allowed SWD stated alcohol searches the room checks once a week, ed there was no documentation devas not aware of any ecurrently using alcohol. SWD re plan and stated alcohol use R7's careplan. Alcohol use was it because something happens ingoing issue I would have put the careplan". The SWD stated alcohol use with R7 and she in R7 said she "would not do it elieves her". SWD stated she inmates (R20, R17) they could in the house nor provide alcohol into into into into into into into into	F 323			

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F 323	supervision and interest the risk for elopemental been committerest initially on 8/5/14, a on 12/30/14. R16 we discharge on 3/31/1 material conditions R16 missed many aclinic and continued contributed to multiper the second in the contributed to multiper the second in	ge 47 ure R16 had appropriate erventions in place to minimize ent and ongoing chemical use. d for chemical dependency as granted a provisional 5, however she violated the of her provisional discharge. Appointments at the primary I to consume alcohol which ple falls and hip injuries. R16 eplacement on 9/16/15. The atified alcohol intoxication upon me. On 10/13/15 a hospital note indicated social worker left a message with social D), "Director at Grand Ave  Human Services and Public Behavioral Services Case information letter dated a long history of R16 being tment centers related to ars. It also identified a long nousing, with R16 currently at er chemical dependency 16. An Individual Community 19 dated 11/10/15-5/8/16, from tated the contact person was Grand Ave Residence ". The longest period of sobriety was expressed interest in sobriety. was to be sober and feel ented strategies included: the return to Huss recovery, men for sobriety, maybe AA, the mental health issues, at Grand Avenue, manage	F3	23		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG	(X3)	) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER  AVENUE REST HOME	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP COI 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409	DE	
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F 323	also identified with did not have a diag The ICSP indicated fetal alcohol syndro pregnant. R16 had other physical healt of alcohol consump Ave Residence in a sobriety and to clos R16 was accepted 11/9/15, under com dependency until 1/2. The Minimum Data indicated R16 was depressed, had ver directed towards ot R16 was independency and had a diabetic. The undated care palcohol intoxication homelessness. The treatment three tim week, and will not a schedule appointment of the control	ount carbohydrates. R16 was anxiety and depression, but nosis of severe mental illness. I R16 had 2 children, both with time, due to her drinking while sustained head injuries and the injuries related to high levels oftion. R16 was placed at Grand order to help encourage sely monitor blood sugar levels. and admitted to the facility on mitment for chemical (1/16.  Set (MDS) dated 12/7/15, cognitively intact, mildly that behavioral symptoms hers, and rejected care daily. The symptomic mitment for chemical continues the symptoms of daily living, and rejected care daily.	F 3	23		

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	facility at specified to The Social Service indicated anxiety are can made poor decorate indicated anxiety are can made poor decorate identified experoutpatient treatmen Nursing progress of PN11/17/15, at 6:00 room to get blood so for glucose monitor to eat supper. Found Was very difficult to confused and did not trying to redirect to with assist of one. Explaced to paramedicate had any alcohol to PN 6:15 p.m. Paramerisident. PN 6:30 p.m. Paramerisident. PN 11/17/15 ETOH concentration] level times the legal limit PN 11/18/15 Writer verified ER, R16 was PN 11/18/15, continues the reat Gradrinking vodka all dare alcohol free res [intoxicated]. PN 11/24/15 Resident state PN 11/25/15 2:00 a to name, denies paupstairs sitting area	ort for failure to return to time.  Assessment dated 11/13/15, and "when intoxicated resident isions and behaviors change." ctations were "Attend it and therapy, stay sober." otes (PN) included:  Dep.m. writer went to resident's ugar. Did not come to office ing. Had stated was not going and resident in (R17's) bed.  Department and writer when room-unable to sit up in bed 3lood sugar level 222. Call cs, questioned resident if she lay, and denied alcohol usage. medics transporting resident to Hospital.  Intoxication [alcohol 0.37 per nurse [more than 3].  placed call to FVR [hospital]:	F3	23			

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	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	Physicians Progres indicated recent ho intoxication-returns assessment. PN 11/27/15 at 9:3 [leave of absence] machine and Novo demonstrated to w verbalizes understaknowledgeable aboapproval by clinic. for LOA, took bus. The undated Resides in the home unless physician. 21. There will be not in the home unless physician. 22. There will be not in the home unless physician. 23. We need to knot times. Residents a leaving the home. Ideatination, contact time of return. The dining room on the 41. When planning the day, staff must planning to be absest aff requires a 24 be away for more to required. Physicians Progresidentified Ok to do discretion. Please of unit/10 gram of car at facility. " [Construction of the commendation of the commendati	n calm. Cooperative. It is so Notes dated 11/25/15, is pitalization due to alcoholed yesterday 11/24/15. Rule 25 of a.m. Resident going on LOA with oral meds, accucheck log insulin pen. Has riter proper use of pen and anding of sliding scale. Is but her medications and has 11:50 a.m. Left with boyfriend lent Rules and Responsibilities 12/1/15, included: a alcoholic beverages allowed a prior approval from the power where residents are at all re required to sign out/in when information needed includes a tinformation, and expected sign out book is located in the fireplace mantel. It to be gone from the facility for be given 2 hour notice. When eart from the facility overnight, hour notice. When planning to han a full day, a 3 day notice is as Notes dated 12/2/15, toxicology screen at facility discontinue Novolog order [I los], "Do not do Carb Counting"	F 323	3		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  IG		TE SURVEY MPLETED
		24E150	B. WING _	<del></del>	04.	/18/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	accurately is not por PN 12/8/15, 10:00 pthen spend day with HS [bedtime]. She is 10:00 p.m. PN 12/8/15, at 11:00 from outing. PN 12/9/15, at 1:00 from outing. PN 12/9/15, at 5:00 from outing with he PN 12/9/15, at 4:30 called and said resi to facility until tomo having car trouble "Mental Health Sum R16 was noncompl long history of alcoldependencies, trea history of unstable at Nystroms Associ Continues to drink at 11/17-11/24 due to boyfriend that is curalcohol for favors. PN 12/10/15, (untin [boyfriend] voice mathis a.m. No return who is resident's auxiliary call boyfriend and lemust contact us with No call back at 2:30 as missing person. PN 12/10/15, 5 p.m report. PN 12/11/15 7:40 p [boyfriend's] number the telephone to R1	ossible in the home"]. coatient left via taxi to doctor in boyfriend. She has meds till states she will be back at  0 has not returned as planned. ift. if a.m. R16 had not returned if a.m. R16 had not returned if boyfriend. if p.m. Residents boyfriend dent will not be coming back if p.m. at 1:00 p.m. "Stated"	F 32	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		24E150	B. WING		04	/18/2016	
	PROVIDER OR SUPPLIER  AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP CO 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	have a working car PN 12/11/15, called PN 10:30 a.m. reside PN 12/11/15, 9 p.m. 8:00 p.m. (late entr PN 12/14/15, at 5 pto [boyfriend's] cell him to have R16 cashe is returning. PN 12/14/15, at 5:1 call from [R16], she evening at around PN 12/14/15, at 8:0 writer/nurse to report tomorrow am becar Resident reports she PN 12/15/15, at 5:3 LOA-stated had "in house was able to why she did not ret some things I had the An undated handwiseason to be jolly when I go to [boyfri would be alright if I be back on the 26th Drinking!!! I under realize what I did w "Please" just take it would mean a lot to PN 12/25/15, at 10 [R16's] boyfriends of [R16] was sleeping PN 12/26/15, at 5:00 return call at boyfrie PN 12/26/15, at 5:00 return call call provided provid	boyfriend's phone to contact. dent [R16] left voice mail. resident did not return at y).  m. Writer/nurse placed a call phone and left a voicemail for all us back to let us know when states she will be back this p.m.  p.m. Resident called by p.m.  p.m. Resident called by p.m.  p.m. Resident called by p.m.  p.m. resident returned from sulin needles" at boyfriends give self-insulin. Writer asked by the care of".  ritten note stated: "Tis the land of take care of".  ritten note stated: "Tis the land I was wonderingif end's] on Christmas Day, if it spent the night? I promise I'll in before 10 p.m.!! Also no retand if you say "NO", as I rong before!![sic] Can you to into consideration? As it omy man and I!![sic]" ent on LOA with meds. Stated	F 3	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		24E150	B. WING	····	04	/18/2016	
_	PROVIDER OR SUPPLIER  AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP COE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 323	on the line. PN 12/26/15, at 6:4 call from [R16], she riverside ER to get until she can have I she will she will be PN 12/26/15, 10:09 from [R16] she stat pneumonia, they ar plan to do a further PN 12/26/15, at 10 riverside ER and sp room nurse. He stat pneumonia. Physicians Progres continues to consult of crystal light. Atte session. PN 1/7/16, Resider member [aunt] cam The interim director written, undated Dia " Currently in hospi peripheral neuropa bone, bladder incord diabetes type II (DN Dislocation. Psychia ETOH abuse, chrof Consumption of alc extended time withe for no overnights or continued therapy f needs clinic involve II. "[R16] was adm hospital. During con non-compliant with alcohol on premise notification. Althouge	ge 53  5 p.m. writer/nurse received a states she is at Fairview pain meds for her hip pain her surgery done. She states back later this evening.  writer /nurse received a call es she is being admitted for e starting her on IV 's and work up on her hip pain.  30 p.m. writer/nurse call FV ooke with [R16's] emergency tes she is being admitted for s Notes dated 12/31/15, [R16] me alcohol-conceals in bottle nded treatment for a first at discharged today, family ne for belongings at 5:00 p.m. of nursing (IDON) 's hand scharge/Summary Information, tal, history alcohol abuse, thy, a vascular necrosis, of hip natinent, esophageal reflux, M II). Secondary Hip atric Conditions: depression, nic pain. Behavior problems: cohol, left premises for out notice. Broke court order atside of facility. Needs or chemical dependency, ment for management of DM natited on 11/9/15, from FVR arse of stay, resident remained facility rules, concerning and leaving facility without the compliant with medical timent programs on course of	F3	23			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI IER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION  NG		E SURVEY PLETED
		24E150	B. WING _		04/	18/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	(SWD) and administ assessments and p SWD stated the rest ask for meds". The one community ass assessment. "If son the outing, I have that 3:00 p.m. the SWLOA ability was usu LOA. The SWD stated to the case manage and the resident has self-administration. LOA assessment. The SWD stated will drinking, she had ca [LICSW], searched the boyfriend. After the elopement reassessments on LOA's. SWD stated going out legally. The discharge or comm what you're going to "Many times if they snow storm you let she "did not think the night." The case more week without any or and then to step more than the step	p.m. the social work designee strator were asked for olicies for resident LOA's. The sidents, "sign LOA form and SWD stated they completed essment and one medicine neone does not return from the missing person's protocol." If you stated the assessment for ally a doctors order for the sted sometimes she would talk or if they had one (LICSW), do to pass medication. The facility did not have a sment they knew R16 was alled the case manager R16's room, and searched the facility lacked R16's ability to continue with "We can't restrict them from the nen you have to look at it it it it it is a do." The administrator stated want to go [out] even in a sthem go." The SWD stated want to go [out] even in a sthem go." The SWD stated want to go fout] even in a sthem go." The swo fout in the facility want to go fout] even in a sthem go." The swo fout in the facility want to go fout] even in a sthem go." The swo fout in the facility want to go fout] even in a sthem go." The swo fout in t	F 3	23		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		DNSTRUCTION		E SURVEY IPLETED
		24E150	B. WING			04/	18/2016
_	PROVIDER OR SUPPLIER  AVENUE REST HOME			3956	ET ADDRESS, CITY, STATE, ZIP CODE  GRAND AVENUE SOUTH  NEAPOLIS, MN 55409	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	adult) no matter who that the leave of ab but was based on a community safety the stated she only work would give bullet propaperwork and then. R6 was observed of walking from dining off the living room. Stumbling and react using any device to the deviation of the living room. Stumbling and react using any device to the deviation of the living room. B6 was observed wand stumbling into a chair in the smoking again observed to see smoking room.  R6's Grand Avenue Prevention Plan (Allindicated potential problems, dizziness clothing and foot was problems, walker who footwear, walker who footwear, walker who footwear, walker who footwear, walker who footwear glasses. APP was rewith no falls identified were identified for the footwear in the falls identified were identified for the fall was considered for the fall in	ge 55 at." The IDON further stated sence was not an assessment other assessments such as nat the SWD did. The IDON ked one day per week, she bints to SWD who filled out in the IDON signed her name.  In 4/12/16, at 6:35 p.m. Iroom table to bathroom, just R6 had a halting gait, was hing for furniture. R6 was not assist with ambulation.  In 4/13/16, at 11:40 a.m. assist with ambulation.  In 4/12/16, at 6:35 p.m.  In 4/12/1	F3	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		24E150	B. WING		04	/18/2016	
	PROVIDER OR SUPPLIER  AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP C 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	11/25/15, added incompany to room R6's care plan daterisk for fall due to greater for fall due to grea	cluded, "do not use upstairs ring noc [night]. If B.R. being ght] for nurse to assist to use B.R."  In to use B.R."  In the description of the second and pants, wear of the facility. If the second and pants, wear of the facility on the care plan included Fall risk three times weekly, labs as resif wearing pants, wear of footwear, and night light on at the 11/25/15, fall with new sted on care plan. The 1/4/16, are plan with no new 2/22/16, fall was not on care  Record and Progress Notes rough 4/13/16, indicated R6 25/15, 1/4/16, and 2/22/16.  9:00 a.m. indicated R6 tripped ne ground and fell on the lave a walker with her. There jury. In the second secon		,			
	the smoke room. R down when the cha - PN on 2/22/16, at roommate informed in the bathroom. Re	6 stated she was about to sit ir slid away from her. 10:30 p.m. identified R6's d the nurse that R6 had fallen 6 initially denied falling in the told the nurse she had slipped					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		LDENTIFICATION NUMBER.		TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		24E150	B. WING		0.	4/18/2016	
	PROVIDER OR SUPPLIER  AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 323	and fell on her knee on her left arm abo encouraged R6 to sitting blood pressur blood pressure was faxed to the physic record lacked any f physician 28 millim drop in systolic blood blood pressure of 1 hypertensive medic R6's quarterly Minin 2/5/16, indicated R6 was independent wexcept dressing an also indicated R6 w sitting to standing of any mobility device breath with walking diagnoses of anem schizophrenia.  The Physician's oro R6 received amlod benazepril for hyper clozapine for schizomedical record was that the facility look regarding the falls a "dizzy."  During interview or interim director of reinvestigated and calinterventions identifications.	ve the elbow. The nurse wear proper footwear. R6's are was 132/80 and standing is 104/70. Vital signs were ian's assistant. The medical follow up information with R6's eters of mercury (mm HG) and the two cations and the clozapine use.  The mum Data Set (MDS) dated 6 was cognitively intact and with all activities of daily living dipersonal hygiene. The MDS was unsteady when going from or turning around, did not use is and R6 became short of it. R6's MDS indicated R6 had it. R6's MDS indicated R6 had it. diabetes, hypertension and ophrenia twice daily, and ophrenia twice daily, and ophrenia twice daily. The is void of any documentation and her stated feeling of being in 4/15/16, at 2:19 p.m. the nurses (IDON) said, all falls are are planned with new	F3	23			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	PLE CONSTRUCTION  3		E SURVEY PLETED
		24E150	B. WING		04/	18/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	noted the following are mild or modera legs or ankles, tired stomach pain, naus warm feeling in you arrhythmia (irregula palpitations (very father than the package insert Pharmaceutical Lal 8/2/13, insructed stomach caregivers about the hypotension and syperiod of initial dose strictly follow the cli instructions for dose patients to consult they feel faint, lose	A Quality Care Products LLC side effects. Most side effects te: headache, swelling of your dness, extreme sleepiness, sea, dizziness, flushing (hot or in face), ar heartbeat) and heart list heartbeat)."  If for clozapine by Caraco poratories, Ltd. revised on aff to inform "patients and	F 323	3		
F 354 SS=F	the section for Stop Injuries (STEADI) repressure to be "dromm Hg, or in diastor experiencing lighther considered abnormal blood pressure and any follow up with the 483.30(b) WAIVER FULL-TIME DON  Except when waive this section, the factor in the section in the	-RN 8 HRS 7 DAYS/WK,  d under paragraph (c) or (d) of illity must use the services of a r at least 8 consecutive hours	F 354	4		5/16/16

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		E SURVEY IPLETED
		24E150	B. WING		04/	18/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 354	Except when waive this section, the fact registered nurse to nursing on a full time. The director of nursing on a full time. The director of nursing only when the occupancy of 60 or This REQUIREMED by:  Based on interview facility failed to prove coverage for eight of a week, and did not the potential to affer facility requiring call Findings include:  Nursing hours were 4/15/16. The review consistently no RN-The weeks of 3/14 there was no RN co 3/24.  The weeks of 3/25 RN coverage on 3/25	age 59  ed under paragraph (c) or (d) of cility must designate a serve as the director of the basis.  Sing may serve as a charge of facility has an average daily fewer residents.  NT is not met as evidenced of and document review, the evide registered nurse (RN) consecutive hours, seven days thave an RN waiver. This had not all the 17 residents in the re and services.	F 3	DEFICIENCY)	have had w that our en unable ON, we I as the ne up until to go to ull this pool, or lve the t that rage for at the place. A	
	RN coverage on 4/ On 4/12/16, at 12:0 manager acknowle	12/16. 00 p.m. the business office dged there was no RN and a new director of nursing		When the DON starts will also h coverage for at least 8 hours pe We are aware of the coverage requirements. As nursing openi we will continue to aggressive as search for and hire nurses to ma requirement.  Those responsible to maintain c	ave RN day. ngs occur dvertise, aintain this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		24E150	B. WING _		04/	18/2016	
	PROVIDER OR SUPPLIER  AVENUE REST HOME	:		STREET ADDRESS, CITY, STATE, ZIP CODE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 354	Continued From pa	ge 60	F 35	will be the DON and supervised by the Administrator.			
F 356 SS=C	483.30(e) POSTED INFORMATION	NURSE STAFFING	F 35			4/18/16	
	a daily basis: o Facility name. o The current date. o The total number by the following cat unlicensed nursing resident care per sl - Registered nu - Licensed prace	and the actual hours worked egories of licensed and staff directly responsible for nift: rses. tical nurses or licensed as defined under State law).					
	specified above on of each shift. Data o Clear and readab	ace readily accessible to					
	make nurse staffing	oon oral or written request, g data available to the public not to exceed the community					
	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 by:	NT is not met as evidenced					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		E SURVEY PLETED
		24E150	B. WING	·····	04/	18/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME	:		STREET ADDRESS, CITY, STATE, ZIP CODE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 356	facility failed to posinursing staff directly per shift on each dapotential to affect a requiring care and serious include:  A review of the posining of the posining include:  A review of the posining of th	and document review, the the actual hours worked for y responsible for resident care ay of the survey. This had the ll the 17 residents in the facility services.  The review identified there on between the registered stical nurse (RN/LPN) e week. It was a work of the wo	F 356	We were documenting the RN and hours together. A simple change form was all that was required. No each shift has a spot to record LPN spot to record RN hours. Nursing trained in the change in use of the To assure compliance with this the following plan has been put into play we were documenting the RN and hours together. A simple change form was all that was required. No each shift has a spot to record LPN spot to record RN hours. Actions taken to identify other pote residents having similar occurrence have updated the form and shredd copies of the outdated form. The DON will monitor this daily and responsible to maintain the records review. The Administrator will ensumaintain compliance.	to the low, N and was form.  Acce.  LPN to the low, N and les. We led to the low of the les. We led to the low of the low	
F 431 SS=D	The facility must en a licensed pharmac of records of receip	DRUG RECORDS, UGS & BIOLOGICALS  Inploy or obtain the services of cist who establishes a system and disposition of all sufficient detail to enable an	F 431			6/9/16
	· ·					

			(X3) DATE SURVEY COMPLETED		
		24E150	B. WING		04/18/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME		3	STREET ADDRESS, CITY, STATE, ZIP CODE 8956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409	,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION
F 431	Continued From pa		F 431		
	records are in orde	tion; and determines that drug r and that an account of all maintained and periodically			
	labeled in accordar professional princip appropriate access	als used in the facility must be not with currently accepted ples, and include the ory and cautionary e expiration date when			
	facility must store a locked compartmen	State and Federal laws, the all drugs and biologicals in the note and the state of			
	permanently affixed controlled drugs list Comprehensive Dr Control Act of 1976 abuse, except whe package drug distri	ovide separately locked, discompartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the hinimal and a missing dose can it.			
	by: Based on observareview, the facility for medications were reart for 1 of 2 resided addition, that all mediabeled with resider	NT is not met as evidenced tion, interview, and document ailed to ensure expired emoved from the medication ents (R17) with diabetes. In edications were properly int's names, directions for use or 1 of 2 residents (R1) with		The Victoza insulin pen found in the cart on 4/12/16 had not been open used yet. It is unfortunate that the pharmacy delivered this medication without proper labeling. Upon interinvestigation we discovered that a discovered the issue with the label	ned or nrnal nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		24E150	B. WING		04/-	18/2016	
	PROVIDER OR SUPPLIER  AVENUE REST HOMI			STREET ADDRESS, CITY, STATE, ZIP 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 431	storage observatio improve blood sug plastic bag labeled no label on the per opened	27 p.m. during the medication n a Victoza (a medication to ars) injectable pen was in a with a first name. There was n or bag. There was no date in the date of th	F4	had brought it to the med of the issue and then forgot to Nursing inspected the remfound them all to be labele discarded the pen without acknowledge that all medic properly labeled and have procedure for checking in offrom the pharmacy to include labeling and to send the mimmediately to the pharmacy labeled.  The open Lantus bottle with date of 3/14/16 and expirated 4/11/16. It should have be 4/11/16 with a 28 day expirated have begun retraining official about medications that are immediately be discarded. Will be completed by the date for the correction. We have medication cart audit policy monitoring the expired date medications as well as open This monitoring occurs at lother week. The Director of monitor this for compliance checking the medication can administrator will also over the DON.	o follow up on it. aining pens and d properly and the label. We cations must be changed our of medications de verifying the edication back cy if improperly h dated open tion date of en last used on ation. We all the nurses expired should This retraining ate indication we updated the y to include e for all ened dates. east every of Nursing will e by spot art. The		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING			E SURVEY PLETED
		24E150	B. WING			04/	18/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP CO 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 431	the opened date. LI expired 28 day afte R1's annually Minim 2/20/16, indicated F diabetes. The MDS insulin injections set The Physician Orderindicated R1 was to at bedtime for diabeted The expiration date days after you first the expiration date days after you first the expiration date days after you first the responsibility Facility Internal Med 5/1/14, instructed so of the medications will be every two weeks." Fitems to audited for "2. Check for and red Dispose of expired procedures. 3. All medications rehave a legible date becoming hard to remust discard as if it Facility Proper Labete The Manual Proper Labete The R1's annually Minimal Proper Labete The M1's annually Minimal Proper Labete The R1's annually Minimal Proper Labete The R1's annually Minimal Proper Labete The M1's annually M1'	2/16. That was 30 days from PN-B verified the Lantus r being opened.  num Data Set (MDS) dated R1 had a diagnosis of indicated R1 had received ven out of seven days.  Preserved Lantus 15 units daily betes.  Preserved Lantus 16 units daily betes.	F4	31			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		E SURVEY PLETED
		24E150	B. WING			04/	18/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME			39	TREET ADDRESS, CITY, STATE, ZIP CODE 956 GRAND AVENUE SOUTH IINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431 F 458 SS=B	directions for use.	d resident's name and  DROOMS MEASURE AT	F 4				5/13/16
	per resident in mult	easure at least 80 square feet iple resident bedrooms, and at et in single resident rooms.					
	by: Based on observate failed to provide at resident in three resident in the resident i	NT is not met as evidenced tion and interview, the facility least 80 square feet per sident bedrooms (101, 102, residents (R1, R2, R4, R6, whose bedroom had fewer potage.			A waiver is requested for rooms 10 and 103 because they do not meet requirements of 80 square feet per resident. We are requesting the wai because: We have operated over 40 years in the same facility. During this there have been no adverse effects the room sizes. Our residents are	the iver 0 is time,	
	room with 211.33 solarge wooden ward which measured 13 square feet of usab each resident.  2) Room 102 had the	nree residents residing in the quare feet of floor space. A robe was built into the room, 8.5 square feet, leaving 197.83 ale space or 66 square feet for the residents residing in the are feet of floor space or 77.3			generally satisfied. Our resident cor are minimal. When a resident does a concern it is generally because the came to our facility from an apartment home and we cannot accommodate many of their belongings as they we prefer. We do try to accommodate to to the extent possible. All of our resi are ambulatory. We do not have whe chairs in the facility and have not encountered any safety or health	have ey ent or e as ould them idents neel	
	room had 238.26 so Three wooden ward room. One wardrob another measured	wo residents residing in the quare feet of floor space. drobes were built into the e measured 6 square feet; 5.3 square feet and the third are feet. That resulted in			problems due to the existing room some of the residents have the opportunity decorate their room and put up difference of the personal items of enjoyment. Our residents have ample room for personal possessions. Each resident has a custom-made locking wardrobe cabo	to erent sonal	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION			E SURVEY PLETED
		24E150	B. WING			04/	18/2016
NAME OF F	PROVIDER OR SUPPLIER				S, CITY, STATE, ZIP CODE	-	
GRAND A	AVENUE REST HOME	<u> </u>		3956 GRAND AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	IDER'S PLAN OF CORRECTIO CORRECTIVE ACTION SHOULD EFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 514 SS=D	220.71 square feet square feet per res On 4/12/16, at 12:0 verified the facility verequirements, and particular waiver regarding the On 4/12/16, at appresidents residing in interviewed and all the space provided 483.75(I)(1) RES RECORDS-COMPLE  The facility must mare resident in accorda standards and practically documents systematically organized information to identification resident's assessmiservices provided; to the square feet per resident's assessmiservices provided; to the square feet per resident square feet	of useable floor space or 73.7 ident.  O p.m. the administrator was aware of the space planned to request a federal eroom measurements.  Toximately 8:45 a.m. the nathese rooms were expressed satisfaction with expressed satisfaction with the contain clinical records on each note with accepted professional attices that are complete; and nized.  Toximately 8:45 a.m. the nathese rooms were expressed satisfaction with the expressed satisfaction with the contain sufficient are complete; and nized.  Toximately 8:45 a.m. the nathese rooms were expressed satisfaction with the contain sufficient are complete; and nized.  Toximately 8:45 a.m. the nathese rooms were expressed satisfaction with accepted professional are contain sufficient are complete; and nized.	F 4	There is enough preferred furthe beds in well and allow issue. Nursing providing nurequest letter system.	ough room for chairs and irniture to the extent poin our rooms fit the space ow for exit and entry withing has not had any prodursing care. The waive er was uploaded to the	ssible. e very thout bblems r	6/3/16
	by: Based on interview facility did not ensu	NT is not met as evidenced and document review, the re retention of complete and ecords for 1 of 3 (R20) been hospitalized.		Correction i deficiency e deficiency v not to be co	n of this response and lis not a legal admission exists or that this statem was correctly cited, and onstrued as an admission facility, the Administrate	that a nent of is also on of	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		24E150	B. WING		04/1	8/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME	:	3	STREET ADDRESS, CITY, STATE, ZIP CODE 8956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 514	Minimum Data Set dated 2/6/16, idential activities of daily lives R20's Community Stated 8/3/15, indical making poor decisic issues and was curthree times per well indicated R20 had and was a "former admission has use assessment further multiple Vulnerable admission related to recommendations of R20 could leave the medical record lack illegal drugs from the through 8/3/15) as A note dated 12/28 signed by the admisadmitted to having contributed to another emergency room. The first time that haviolation of the facilistated that addition to ensure the safety residents and sugging random room check medical record didincidents related to R20's Progress No.	to the facility on 3/23/15. A (MDS) annual assessment fied R20 as independent with ing and had intact cognition.  Safety Assessment (CSA) ated R20 had a history of ons, chemical dependency rently attending treatment ex. The assessment further a history of substance abuse heroin addict" and that "since dillegal drugs." The indicated that R20 had Adult (VA) issues since to poor choices. Staff on the assessment indicated a facility independently. R20's are documentation of use of the time of admission (3/23/15 and dentified in the CSA.  A 15, in R20's medical record alcohol in her room which her resident (R7) going to the The note indicated that was not ad occurred and that was a ity policy. The note further all interventions were required and the other ested R20 was now subject to the sand a room change. R20's not identify previous dates or	F 514	any employees, agents, or other individuals who draft or may be di in this Response and Plan of Corr In addition, preparation and submithis Plan of Correction does not can admission or agreement of any the facility of the truth of any fasts or the correctness of any conclusiforth in the allegations.  Accordingly, the facility has preparally plan of Corrections prior to resolution any dispute resolution which must because of the requirements under and federal law that mandate subtof a Plan of Correction within tendays of the delivery of the CMS-2 allegations of deficiencies as a costological participate in the programs. Tof Correction is submitted as the forcedible allegation of compliance. We are disputing this tag in the indispute resolution process to corremany inaccuracies reported.  To assure compliance with this the following plan has been put into process to corremany inaccuracies reported.  To assure compliance with this the following plan has been put into process to corremany inaccuracies reported.  Actions taken to identify other pot residents having similar occurrence have reviewed each hospital discharge summary.  Actions taken to identify other pot residents having similar occurrence have reviewed each hospital discharge summary.  We have retrained the nurses that information in a discharge summary.  We have retrained the nurses that information in a discharge summary.  We have retrained the nurses that information in a discharge summary be included in the resident medical record.	rection. ission of onstitute y kind by alleged ons set red this tion of the filed er state mission (10) 567 andition his Plantacility s formal ect the lace. ave scharge and ential ces. We n in I record arge that ary must	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24E150	B. WING			04/-	18/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME	:		39	TREET ADDRESS, CITY, STATE, ZIP CODE 956 GRAND AVENUE SOUTH IINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	On 2/3/16, at 7:30 a lethargic although a asked. R20 was give and stated "I'm just later, R20 states should be stated to her store again after the nurse which stated they "nurse found resider and neck hyperexter and breathing, pulse 80/bpm [beats per not responsive-pupattendants gave National and resident responsive entified. On 2 below the above er state they found a sthem. R20 not report his nurse on duty from the state resident admit 2/3/16, at 5:00 p.m for heroin overdose documentation to the suicide note in R20 R20's Hospital Discindicated R20 had hospitalization for a accidental overdose R20's medical record from the suicide summary and an entry tracking on 1/13/16. When a state of the suicide summary and an entry tracking on 1/13/16. When a state of the suicide summary and an entry tracking on 1/13/16. When a state of the suicide summary and an entry tracking on 1/13/16. When a state of the suicide summary and an entry tracking on 1/13/16. When a state of the suicide summary and an entry tracking on 1/13/16. When a state of the suicide summary and an entry tracking on 1/13/16. When a state of the suicide summary and an entry tracking on 1/13/16. When a state of the suicide summary and an entry tracking on 1/13/16. When a state of the suicide summary and an entry tracking on 1/13/16. When a state of the suicide summary and an entry tracking on 1/13/16. When a state of the suicide summary and an entry tracking on 1/13/16. When a state of the suicide summary and the	a.m. resident appeared able to respond to questions if yen five ounces of apple juice so thirsty." One half hour he could not eat breakfast and mach." R20 was checked he was called by roommates were worried" about R20. The nt "laying across bed with head ended. Res. [resident] warm he approx [approximately] minute] and strong. Res. just hils dilated. 911 was calleddracan [a heroin reversal agent] anded and was taken to ER the physician and family (3/16, a "Postnote" was written hitry that indicated "EMTS [sic] suicide note and took it with writed any suicidal thoughts to from 7am-3pm. EMTS [sic] tited for snorting heroin." On R20 was admitted to hospital be information regarding R20's "s medical record.	F 5	14	record. The DON is responsible f implementation and regular monito and spot checking of this going for The Administrator is responsible to maintain compliance and will do thi spot checking with the DON period	ring ward. s by	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		E SURVEY IPLETED
		24E150	B. WING _		04/	18/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 514	(SWD) stated the h with any written sur nurse (LPN)-A state medication list, so the R20's labs were revested positive for R20's medical recordion follow up for the positive of R20's medical recordion follow up for the positive of R20 had any other overdose on 2/3/16 R20 had any other overdose. The SWI with the hospital on found, which she in not a suicide note. was no documental medical record about she "wanted to live. R20's past drug us positive for marijual that was not indicated. Interview with the ir (IDON) on 4/15/16, someone at the fact hospital on the "suinote was actually a note. The IDON stat have been docume	n. the social work designee ospital had not provided them nmary. Licensed practical ed they only needed the he rest was shredded.  viewed which indicated R20 THC (marijuana) on 3/26/16. rd did not indicate any further	F 51			
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEN QUARTERLY/PLAN		F 52	0		6/3/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		E SURVEY PLETED
		24E150	B. WING		04/	18/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP COE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 520	A facility must main assurance committed nursing services; a facility; and at least facility's staff.  The quality assessing committee meets a issues with respect and assurance actifuted develops and imples action to correct idea. A State or the Secution of the respect insofar as succept insofar a	age 70  Intain a quality assessment and the consisting of the director of physician designated by the transport of the transp	F 5	DEFICIENCY)  20		
	review, the facility f Assessment (QA) of developed action p injury for 4 of 4 resi were required supe known to consume in the facility. Findings include:	tion, interview and document failed to ensure the Quality committee recognized and lans to address potential for idents (R6, R7, R16, R20) who ervision for falls and were alcohol and use illegal drugs facility did not supervise and		Submission of this response Correction is not a legal admis deficiency exists or that this sideficiency was correctly cited, not to be construed as an admisalt by the facility, the Adminiany employees, agents, or oth individuals who draft or may be in this Response and Plan of In addition, preparation and suthis Plan of Correction does not an admission or agreement of	ession that a tatement of and is also nission of strator or ner e discussed Correction. Ubmission of ot constitute	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		SURVEY PLETED
		24E150	B. WING		04/-	18/2016
NAME OF PROVIDER OR SUPPLIER  GRAND AVENUE REST HOME				STREET ADDRESS, CITY, STATE, ZIP C 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 520	provide intervention hospitalizations for and R20.  The Social Service interviewed on 4/15 administrator prese QA committee that issues, discuss new and struggles of the The SWD was interpedicted. The SWD was interpedicted at 3:00 and elopement. The history of drug use, alcohol dependence alcohol and drugs wat anytime and was that were currently	Designee (SWD) was 1/16, at 5:03 p.m. with the 1/16, at 5:03 p.m. with the 1/16 and confirmed there was a 1/16 met and 1/16	F 5	,	prepared this resolution of a must be filed as under state to submission and the facility is the facility is the facility is the informal at the accidents are also mation. In the facility is the informal at the accidents are also mation. In the facility is the informal at the accidents are also mation. In this the into place, and the facility is the informal additional did. We did add add to reduce the facility of the facility is the into place. The facility is the into place and the facility of the facility is the into place. The facility is the into place and the facility is the into place. The facility is the into place and the facility is the into place. The facility is the into place and the facility is the into place and the facility is the into place. The facility is the into place and the facility is the into place and the facility is the into place and the facility is the into place. The facility is the facility is the into place and the facility is t	
				residents having similar occ During the scheduled QA m	urrences.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24E150	B. WING			04/-	18/2016	
	PROVIDER OR SUPPLIER  AVENUE REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE  3956 GRAND AVENUE SOUTH  MINNEAPOLIS, MN 55409					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 520	Continued From pa	ge 72	F 5		5/19/16, the team reviewed falls ar incidents for the past year. We alrest this for the past quarter for each Queeting. We determined no additional interventions required for other rest. We will continue to review incidents falls at each quarterly QA meeting, determine if any of the incidents recloser scrutiny, investigate and implicate interventions as necessary. We wis begin documenting this in a separate within the QA documents so we caprovide them for review if this issued comes up again.  Implementation of changes will be 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 Administrator during QA meetings.	eady do A onal idents. s and quire olement II also tte form n e by the er ed. the		

#### 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.

debul

Sincerely.

Allen Soderbeck Administrator

FE150024

PRINTED: 05/18/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 24E150 B: WING 04/12/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3956 GRAND AVENUE SOUTH **GRAND AVENUE REST HOME** MINNEAPOLIS, MN 55409 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 **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:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

**Electronically Signed** 

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

Facility ID: 00208

PRINTED: 05/18/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01			
24E150			B. WING		04/12/2016		
NAME OF PROVIDER OR SUPPLIER  GRAND AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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)			PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(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.		K 000				
K 012 SS=F	responsible for corprevent a reoccurr.  This 2-story buildin Type V(000) construction is fully fire sprinkle a fire alarm system corridors and space monitored for autonotification. The fa and had a census.  The requirement a NOT MET as evide NFPA 101 LIFE SA Building construction of the following: 19.1.6.2, 19.1.6.3, This STANDARD Based on observations are supported by the standard process and the standard process.	on type and height meets one 19.1.6.4, 19.3.5.1 is not met as evidenced by: tion and interview, this building requirements for construction his deficient practice could	<b>K</b> 01:	Correction not needed. Grand A Rest Home has achieved a pass score (see enclosed FSES/HC)		5/5/16	

Facility ID: 00208

PRINTED: 05/18/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION IG <b>01 - Main Building 01</b>		E SURVEY PLETED
		24E150	B. WING _		04/	12/2016
NAME OF PROVIDER OR SUPPLIER  GRAND AVENUE REST HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
K 012	2:00 PM on 4/12/20 this 1903, 2-story, Type V(000) construction type and height. This deficient pract Administrator Assist inspection.  Note: This deficient FSES can establishevel of fire safety of the Life Safety Coonstruction of the Life Safety Coonstruction of the Section shall be smoke-proof enclopassageway. Only a horizontal exit. Enter through the 18.2.4.2, 19.2.4.1, This STANDARD Based on observation approved remote of second floor. This all residents.  Findings include:  During a tour of the 2:00 PM on 4/12/20 the outside fire escond.	e facility between 11:30 AM and 2016, observation revealed that fully fire sprinklered building of fruction does not meet the tion requirements of the code.  Itice was verified by the stant at the time of the code of the c	K 01	·		5/5/16

Event ID: WCGU21

PRINTED: 05/18/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES NND PLAN OF CORRECTION				IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		24E150	B, WING		04/	12/2016	
NAME OF PROVIDER OR SUPPLIER  GRAND AVENUE REST HOME				STREET ADDRESS, CITY, STATE, ZIP 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
K 050	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		K 05	Night shift fire drills will be varied times. A fire drill sch developed for the remaind for use ongoing to ensure are conducted at times of variation. (see attached) T times continue to be varied will review times of the prefire drills prior to establish schedule for the following a reoccurrence of this defi	nedule has been der of 2016 and that fire drills increased to ensure that d, Administrator eceding year's ng the fire drill years to prevent		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00208

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	, ,	TIPLE CONSTRUCTION NG <b>01 - Main Building 0</b> 1		E SURVEY IPLETED
		24E150	B, WING.		04/	12/2016
NAME OF PROVIDER OR SUPPLIER  GRAND AVENUE REST HOME				STREET ADDRESS, CITY, STATE, ZIP C 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(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.		K 0	Correction not needed. Gra Rest Home has achieved a score (see enclosed FSES/	passing FSES	5/5/16
K 050 SS=D	Administrator Assis inspection.  Note: This deficience FSES can establish level of fire safety ethe Life Safety Cod NFPA 101 LIFE SAFIRE drills include the signal and simulation conditions. Fire drill times under varying on each shift. The sand is aware that droutine. Responsible conducting drills is persons who are que Where drills are considered.	e transmission of a fire alarm on of emergency fire is are held at unexpected g conditions, at least quarterly staff is familiar with procedures rills are part of established lity for planning and assigned only to competent ualified to exercise leadership. Inducted between 9:00 PM and announcement may be used	K 0:	50		4/20/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G <b>01 - MAIN BUILDING</b> 01		E SURVEY IPLETED
		24E150	B, WING _		04/	12/2016
NAME OF PROVIDER OR SUPPLIER  GRAND AVENUE REST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
K 032	This deficient pract Administrator Assis inspection.  Note: This deficient FSES can establish level of fire safety ethe Life Safety Cod NFPA 101 LIFE SA Exit enclosures (su with construction had tleast one hour, a continuous path of against fire or smol building. 7.1.3.2, 8. This STANDARD i Based on observation enclosure of this farequired one (1) ho This deficient pract Findings include:  During a tour of the 2:00 PM on 4/12/20 wall construction of constructed of plas studs, which does in	ice was verified by the tant at the time of the cy need not be corrected if an a that the facility has an overall equivalent to that required by	K 03	2	assing FSES	5/5/16
		ice was verified by the tant at the time of the				
	FSES can establish	cy need not be corrected if an a that the facility has an overall equivalent to that required by e.				

#### 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: Robert L. Imholte, President Fire Safety Resources, LLC 16768 County Road 160 Cold Spring, MN 56320 320-685-8559 RimholteFiresafe@aol.com



16768 County Road 160 Cold Spring, MN 56320 (320) 685-8559

E-mail: <u>RImholteFiresafe@aol.com</u>

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.
- o 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 S. Indials

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.

Page 2 of 7

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.

Page 3 of 7

### **Zone 1 – Basement Level:**

### **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 1%-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.

Page 4 of 7

### 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.

### Zone 2 – First Floor:

### **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.

Page 5 of 7

### **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 1%-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.

Page 6 of 7

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.

### **Zone 3 – Second Floor:**

### **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.

Page 7 of 7

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 1%-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*.

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

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

Form Approved **OMB** Exempt

ZONE

ZONES

### FIRE/SMOKE ZONE\* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

	2000 LIFE SAFETY CODE
FACILITY 0 11	BUILDING
GRAND AVENUE REST HOME	01-MAIN BUILDING
ZONE(S) EVALUATED	
BASEMENT	
PROVIDER/VENDOR NO.	DATE OF SURVEY
24E150	04/21/2016
COMPLETE THIS WORKSHEET FOR EACH ZONE. WHONE WORKSHEET CAN BE USED FOR THOSE ZONE:	ERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, S.
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. OCCUPANC	Y RISK PARAM	ETER F	ACTOR	S	
Risk Parameters		Risk F	actors Values				
1. Patient	Mobility Status	Mobile	Limited M	lobility	No	t Mobile	Not Movable
Mobility (M)	Risk Factor	1.0	1.6			3.2	4.5
2. Patient Density (D)	No. of Patients	1–5	6–10	0		11–30	>30
Density (D)	Risk Factor	1.0	1.2			1.5	2.0
3. Zone	Floor	<b>1</b> st	2 <sup>nd</sup> or 3 <sup>nd</sup>	4 <sup>th</sup> to	o 6 <sup>th</sup>	7th and Above	e Basements
Location (L)	Risk Factor	1.1	1.2	1.	.4	1.6	1.6
4. Ratio of Patients to	<u>Patients</u> Attendant	<u>1–2</u> 1	<u>3–5</u> 1	<u>6-</u>	<u>10</u> I	<u>&gt;10</u>	One or More None
Attendants (T)	Risk Factor	1.0	1.1	1.	2	1.5	4.0
5. Patient Average	Age	Under 65 Yea	ars and Over 1 year		65 Yea	ars and Over 1 Ye	ear and Younger
Age (A)	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. OCC	UPANC	Y RISK I	ACTOR	CALCU	LATION	
OCCUPANCY RISK	M X	D X	L X	T X	A =	

- 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)	TABLE 3B. (EXISTING BUILDINGS)
1.0 x = R	0.6 x J.b = [1,0]

\* FIRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers. SURVEYOR SIGNATURE DATE TITLE 04/22/2016 Robert J. Intalle FIRE AUTHORITY SIGNATURE DATE Fire Safety Supervisor Thomas Linhoff

Form CMS-2786T (02/2013)

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.

			TABL	E 4.				
Safety Parameters			Safe	ety Paran	neters Va	alues		
1. Construction	Ту	Combustible pes III, IV, and V					NonCombus Types I an	
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	2	4
Third	-9	-7	-9	-7	7	-7	2	4
4th and Above	-13	-7	-13	-7	7	-9	-7	4
Interior Finish     (Corridors and Exits)	Class C -5(0) <sup>f</sup>	Class E	3	Clas	ss A			<u> </u>
3. Interior Finish	Class C	Class E	}	Clas	ss A			
(Rooms)	-3(1) <sup>f</sup>	1(3) <sup>f</sup>			3)	-		
4. Corridor	None or Incomplet	e <1/2 hou	r	≥¹/₂ to <	1 hour		≥1 hour	
Partitions/Walls	-10(0) <sup>a</sup>	0		(10)			2(0) <sup>a</sup>	
5. Doors to Corridor	No Door	<20 min F	PR	≥20 mi	n FPR		min FPR and Auto Clos.	
	-10	0		1(0	D) <sub>q</sub>		(2(p) <sup>d</sup>	
6. Zone Dimensions		Dead End		`		No Dea	d Ends >30 ft and	Zone Length Is
	>100 ft	>50 ft to 100 ft	30 f	t to 50 ft	>150		100 ft to 150 ft	<100 ft
	-6(0) <sup>b</sup>	-4(0)b)	-	-2(0) <sup>b</sup>	-2(0	))°	0	1
7. Vertical Openings	Open 4 or More	Open 2 o			Enc	closed with	n Indicated Fire Re	sist
7	Floors	Floors		<1			hr to <2 hr	≥2 hr
	-14	-10		(0	0)		2(0) <sup>e</sup>	3(0) <sup>e</sup>
8. Hazardous Areas	Double	Deficiency			Single I	Deficiency	,	No Deficiencies
	In Zone	Outside Zo	one	In Z	Zone	In A	djacent Zone	
	-11	-5		-	·6		-2	(0)
9. Smoke Control	No Control	Smoke Ba Serves Zo			Mech. Ass by	isted Syst	ems	
	-5(0)°)	0				3		
10. Emergency	<2 Routes				Multip	le Routes	- Land	
Movement Routes		Deficien	t		orizontal kit(s)		Horizontal Exit(s)	Direct Exit(s)
	(-8)	-2			0		1	5
11. Manual Fire Alarm	No Man	ual Fire Alarm			Manua	I Fire Alar	m	
				W/O F.	D. Conn.	V	V/F.D. Conn	
		-4			1		(2)	
12. Smoke Detection and Alarm	None	Corridor C	nly	Room	ns Only		orridor and oit. Spaces	Total Spaces In Zone
	0 <b>(</b> 3) <sup>g</sup> )	2(3) <sup>g</sup>		3(	(3) <sup>g</sup>		4	5
13. Automatic Sprinklers	None	Corridor a Habit. Spa			ntire Iding			
	0	8		(-	10)	7		

NOTE: a Use (0) where parameter 5 is -10.

For SI units: 1 ft = 0.3048 m

<sup>&</sup>lt;sup>b</sup> Use (0) where parameter 10 is -8.

<sup>&</sup>lt;sup>c</sup> Use (0) on floor with fewer than 31 patients (existing buildings only)

<sup>&</sup>lt;sup>d</sup> Use (0) where parameter 4 is -10.

<sup>&</sup>lt;sup>e</sup> Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200")

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.

<sup>&</sup>lt;sup>g</sup> 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 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<sub>1</sub>, S<sub>2</sub>, S<sub>3</sub>, S<sub>G</sub> to blocks labeled S<sub>1</sub>, S<sub>2</sub>, S<sub>3</sub>, S<sub>G</sub> in Table 7 on page 4 of this sheet.

TA	BLE 5. INDIVIDUAL	SAFETY EVALUAT	IONS	
Safety Parameters	Containment Safety (S <sub>1</sub> )	Extinguishment Safety (S <sub>2</sub> )	People Movement Safety (S <sub>3</sub> )	General Safety (S₄)
1. Construction	-7	-7		-7
Interior Finish     (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	١			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	STATE OF THE STATE	2		2
12. Smoke Detection and Alarm		3	3	3
13. Automatic Sprinklers	io	10	10 ÷2=5	10
Total Value	S1= 12	S2= 8	<b>S</b> ₃= 5	<b>S</b> 4=9

MANDATORY SA	AFETY REQUIF		LE 6. R USE IN HOS	PITALS OR NU	RSING HOME	S)
		nment Sa)	Extingui (S			lovement
Zone Location	New	Exist.	New	Exist.	New	Exist.
1 <sup>st</sup> story 2 <sup>nd</sup> or 3rd story <sup>b</sup> 4 <sup>th</sup> story or higher	11 15 18	5 9 9	15(12) <sup>a</sup> 17(14) <sup>a</sup> 19(16) <sup>a</sup>	4 ⑥ 6	8(5) <sup>a</sup> 10(7) <sup>a</sup> 11(8) <sup>a</sup>	1 ③ 3

a. Use ( ) in zones that do not contain patient sleeping rooms.

b. For a 2<sup>nd</sup> 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<sub>a</sub>=7, S<sub>b</sub>=10, and S<sub>c</sub>=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 Sa, Sb, and Sc 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 EQU	IVALENCY EVALUATION	Yes	No
Containment Safety (S <sub>1</sub> )	minus	Mandatory Containment (S₃)	≥ 0	$\begin{bmatrix} S_1 & S_a & C \\ 12 & - & Q \end{bmatrix} = \begin{bmatrix} C & 3 \end{bmatrix}$	1	
Extinguishment Safety (S <sub>2</sub> )	minus	Mandatory Extinguishment (S₀)	≥ 0	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	1	
People Movement Safety (S <sub>3</sub> )	minus	Mandatory People Movement (S₀)	≥ 0	S <sub>3</sub> - S <sub>c</sub> P 2	/	
General Safety (S <sub>4</sub> )	minus	Occupancy Risk (R)	≥ 0	$\begin{bmatrix} S_4 & R & G \\ Q & - \end{bmatrix} = \begin{bmatrix} B \end{bmatrix}$	/	

	TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEE	Т		
	mplete one copy of this worksheet for each facility. r 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.			1
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.	1		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	1		
E.	There are no flue-fed incinerators.	1		
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.	1		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	1		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	J		
1.	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.			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.

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

### APPROVED By Tom Linhoff at 9:04 am, May 12, 2016

Form Approved OMB Exempt

ZONE <u>2</u> OF

ZONES

### FIRE/SMOKE ZONE\* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

	2000 LIFE SAFETY CODE
FACILITY	BUILDING .
GRAND AVENUE REST HOME	OI-MAIN BUILDING
ZONE(S) EVALUATED	
FIRST FLOOR	
PROVIDER/VENDOR NO.	DATE OF SURVEY
24E150	04/21/2016
COMPLETE THIS WORKSHEET FOR EACH ZON	NE. 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 PARAMI	ETER F	ACTOR	5	
Risk Parameters		Risk F	actors Values				
1. Patient	Mobility Status	Mobile	Limited M	lobility	No	t Mobile	Not Movable
Mobility (M)	Risk Factor	1.0	1.6			3.2	4.5
2. Patient Density (D)	No. of Patients	1–5	6–10	)	9	11–30	>30
Density (D)	Risk Factor	1.0	1.2		(	1.5	2.0
3. Zone	Floor	1 <sup>st</sup>	2 <sup>™</sup> or 3 <sup>™</sup>	4 <sup>th</sup> to	o 6 <sup>th</sup>	7 <sup>th</sup> and Abov	e Basements
Location (L)	Risk Factor	1.1	1.2	1.	.4	1.6	1.6
4. Ratio of Patients to	<u>Patients</u> Attendant	<u>1–2</u> 1	<u>3–5</u> 1	6-	<u>10</u> I	<u>&gt;10</u> 1	One or More None
Attendants (T)	Risk Factor	1.0	1.1	1.	.2	1.5	4.0
5. Patient Average	Age	Under 65 Yea	ars and Over 1 year		65 Yea	ars and Over 1	ear and Younger
Age (A)	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							
OCCUPANCY RISK	M i.o x	D 1.5 X	( ].l ×	T 4.0 X	A =	<b>F</b>	

- 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)	TABLE 3B. (EXISTING BUILDINGS)
1.0 x = R	$\begin{array}{cccccccccccccccccccccccccccccccccccc$

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

SURVEYOR SIGNATURE	TITLE -	DATE / /
Robert of Impatte, FIRE SAFETY KESOURCES, LLC	PRESIDENT	04/22/2016
FIRE AUTHORITY SIGNATURE	TITLE	DATE
Thomas Linhoff	Fire Safety Supervisor	05-12-2016
Form CMS-2786T (02/2013)	——————————————————————————————————————	Page 1

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.

			TABL	E 4.				
Safety Parameters			Safe	ety Paran	neters Va	lues		
1. Construction	Ту	Combustible pes III, IV, and V			NonCombu Types I ar			
Floor or Zone	000	111	200	211 + 2HH		000	111	222, 332, 433
First	(-2)	0	-2	C	)	0	2	2
Second	-7	-2	-4	-2	2	-2	2	4
Third	-9	-7	-9		7	-7	2	4
4th and Above	-13	-7	-13	-	7	-9	-7	4
Interior Finish     (Corridors and Exits)	Class C -5(0) <sup>f</sup>	Class I	3	Clas				1
3. Interior Finish	Class C	Class I	3	Clas				
(Rooms)	-3(1) <sup>f</sup>	(1)B) <sup>f</sup>		3	3			
4. Corridor	None or Incomplet		ır	≥¹/₂ to <	<1 hour		≥1 hour	
Partitions/Walls	-10(0) <sup>a</sup>	0		1)	D) <sup>a</sup>		2(0) <sup>a</sup>	
5. Doors to Corridor	No Door	<20 min F	PR	<u>≥</u> 20 mi	n FPR		min FPR and Auto Clos.	2
	-10	(0)		1(0	D) <sup>d</sup>		2(0) <sup>d</sup>	
6. Zone Dimensions		Dead End	Dead End			No Dead Ends >30 ft ar		Zone Length Is
	>100 ft >50 ft to 100 ft		30 f	ft to 50 ft >150		ft	100 ft to 150 ft	<100 ft
	-6(0) <sup>b</sup>	-4(0) <sup>b</sup>		-2(0) <sup>b</sup> -2(0)		° 0		(1)
7. Vertical Openings	Open 4 or More	Open 2 o	r 3		End	losed wit	h Indicated Fire Re	sist.
	10 DELENGATION	Floors Floors		<1 hr		≥′	I hr to <2 hr	≥2 hr
	-14	-10		0			2(0) <sup>e</sup>	3(0) <sup>e</sup>
8. Hazardous Areas	Double	Deficiency		Single Deficiency			No Deficiencies	
	In Zone	Outside Z	one	In Zone		In A	djacent Zone	
	-11	-5		-6		-2		(0)
9. Smoke Control	No Control	Smoke Ba Serves Z		Mech. Assisted Systems by Zone			ems	
	-5(0)°)	0		3				
10. Emergency	<2 Routes			Multiple Routes				
Movement	500 1 5			W/O H	orizontal	Horizontal		
Routes		Deficier	nt	Ex	cit(s)		Exit(s)	Direct Exit(s)
	(-8)	-2			0		1	5
11. Manual Fire Alarm	No Man	ual Fire Alarm			Manual	Fire Alar	m	
				W/O F.	D. Conn.	V	V/F.D. Conn	
		-4	4		1		2	
12. Smoke Detection and Alarm	None	Corridor (	Corridor Only		ns Only	Corridor and Habit. Spaces		Total Spaces In Zone
	0(3) <sup>g</sup>	2(3) <sup>g</sup>	)	3(3) <sup>g</sup>			4	5
13. Automatic Sprinklers	None	Corridor a	and	Er	ntire Iding			
	0	8		(	10)	1		

NOTE: a Use (0) where parameter 5 is -10.

For SI units: 1 ft = 0.3048 m

<sup>&</sup>lt;sup>b</sup> Use (0) where parameter 10 is -8.

<sup>&</sup>lt;sup>c</sup> Use (0) on floor with fewer than 31 patients (existing buildings only)

<sup>&</sup>lt;sup>d</sup> Use (0) where parameter 4 is -10.

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.

<sup>&</sup>lt;sup>9</sup> 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 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<sub>1</sub>, S<sub>2</sub>, S<sub>3</sub>, S<sub>G</sub> to blocks labeled S<sub>1</sub>, S<sub>2</sub>, S<sub>3</sub>, S<sub>G</sub> in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS						
Safety Parameters	Containment Safety (S <sub>1</sub> )	Extinguishment Safety (S <sub>2</sub> )	People Movement Safety (S <sub>3</sub> )	General Safety (S₄)		
1. Construction	-2	-2		-2		
Interior Finish     (Corr. and Exit)	3		3	3		
3. Interior Finish (Rooms)	J			1		
4. Corridor Partitions/Walls	1		Province Control	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	and the second of the second o	2		2		
12. Smoke Detection and Alarm		3	3	3		
13. Automatic Sprinklers	10	10	10 ÷2=5	10		
Total Value	S1= 13	S2= 13	S3= 4	S4= \\		

TABLE 6. MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)						
	Containment Extinguishment People Movement (Sa) (Sb) (Sc)					
Zone Location	New	Exist.	New	Exist.	New	Exist.
1 <sup>st</sup> story	11	5	15(12) <sup>a</sup>	4	8(5) <sup>a</sup>	1
2 <sup>nd</sup> or 3rd story <sup>b</sup>	15	9	17(14) <sup>a</sup>	6	10(7) <sup>a</sup>	3
4 <sup>th</sup> story or higher	18	9	19(16)ª	6	11(8) <sup>a</sup>	3

a. Use ( ) in zones that do not contain patient sleeping rooms.

b. For a 2<sup>nd</sup> 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: Sa=7, Sb=10, and Sc=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 Sa, Sb, and Sc 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						No
Containment Safety (S <sub>1</sub> )	minus	Mandatory Containment (S <sub>4</sub> )	≥ 0	$\begin{bmatrix} S_1 & S_a & C \\ 13 & - 5 \end{bmatrix} = \begin{bmatrix} C \\ B \end{bmatrix}$	/	
Extinguishment Safety (S <sub>2</sub> )	minus	Mandatory Extinguishment (S₀)	≥ 0	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	J	
People Movement Safety (S <sub>3</sub> )	minus	Mandatory People Movement (S₀)	≥ 0	$\begin{bmatrix} S_3 \\ L_y \end{bmatrix} - \begin{bmatrix} S_c \\ 1 \end{bmatrix} = \begin{bmatrix} P \\ 3 \end{bmatrix}$	1	
General Safety (S₄)	minus	Occupancy Risk (R)	≥ 0	$\begin{array}{c c} S_4 & R & G \\ \hline & & 5 \end{array} = \begin{array}{c c} G \\ \hline & & 6 \end{array}$	1	

	TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET						
	mplete one copy of this worksheet for each facility. r each consideration, select and mark the appropriate column.	Met	Not Met	Not Applic.			
A.	Building utilities conform to the requirements of Section 9.1.	1					
В.	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.			J			
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.	1					
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	J					
E.	There are no flue-fed incinerators.	J					
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.	J					
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	J					
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	1					
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	J					
J.							
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	1					
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			1			

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 <i>Life Safety Code</i> .*
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 <i>Life Safety Code</i> .*
*The equivalency covered by this worksheet includes the majority of considerations covered by the <i>Life Safety Code</i> . 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.

PROVIDER/VENDOR NO.

Form Approved **OMB** Exempt

ZONE

2016

ZONES

### FIRE/SMOKE ZONE\* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

			2000 LIFE SAFETY CODE
FACILITY		BUILDING	
	GRAND AVENUE REST HOME	OI-MAIN BUILDING	
ZONE(S) EV	ALUATED STAGUE FLAGE		

DATE OF SURVEY

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.

245150

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 Status	Mobile	Limited M	obility	Not Mobile		Not Movable	
Mobility <i>(M)</i>	Risk Factor	1.0	1.6	1.6		3.2	4.5	
2. Patient	No. of Patients	1–5	6–10	)		11–30	>30	
Density (D)	Risk Factor	1.0	1.2			1.5	2.0	
3. Zone	Floor	1 <sup>st</sup>	2 <sup>nd</sup> or 3 <sup>nd</sup>	4 <sup>th</sup> to 6 <sup>th</sup>		7 <sup>th</sup> and Abov	e Basements	
Location (L)	Risk Factor	1.1	1.2	1.4		1.6	1.6	
4. Ratio of Patients to	<u>Patients</u> Attendant	<u>1–2</u> 1	<u>3–5</u> 1	<u>6-</u>	<u>10</u> I	<u>&gt;10</u> 1	One or More None	
Attendants (T)	Risk Factor	1.0	1.1	1.1 1.2		1.5	4.0	
5. Patient	Age	Under 65 Yea	ars and Over 1 year		65 Years and Over 1 Year and Younger			
Age (A)	Average Age (A) 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. OCC	CUPANCY F	RISK FACTO	R CALCUI	ATION	
OCCUPANCY RISK	M E	D L 5 x 1.2 x	T (4.0 X	A 1.2 =	F 8.b

- 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)	TABLE 3B. (EXISTING BUILDINGS)
1.0 x = =	$\begin{array}{ccc} \mathbf{F} & \mathbf{R} \\ 0.6 & \mathbf{x} & \mathbf{g.b} & = 5.2 & = 6 \end{array}$

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

sent of Impolle FIRE AUTHORITY SIGNATURE Thomas Linhoff

Form CMS-2786T (02/2013)

TITLE

DATE

DATE

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.

			TABL	E 4.				
Safety Parameters			Safe	ety Paran	neters Va	alues		
1. Construction	Ту	Combustible pes III, IV, and V					NonCombus Types I an	
Floor or Zone	000	111	200	211 +	2HH	000	111	222, 332, 43
First	-2	0	-2	0		0	2	2
Second	(-7)	-2	-4	-2	2	-2	2	4
Third	-9	-7	-9	-7	7	-7	2	4
4th and Above	-13	-7	-13	-7	7	-9	-7	4
Interior Finish     (Corridors and Exits)	Class C -5(0) <sup>f</sup>	Class E	3	Clas			11	
3. Interior Finish (Rooms)	Class C -3(1) <sup>f</sup>	Class E	3	Clas	s A			
4. Corridor	None or Incomplet		r	≥¹/₂ to <			>1 hour	
Partitions/Walls	-10(0) <sup>a</sup>	(0)	1	2/12 10 4			≥1 hour 2(0) <sup>a</sup>	
5. Doors to Corridor	No Door	<20 min F	PR		≥20		min FPR and Auto Clos.	
	-10	0		1(0	D) <sup>d</sup>		2(0) <sup>d</sup>	
6. Zone Dimensions		Dead End				No Dea	d Ends >30 ft and	Zone Length Is
	>100 ft	>50 ft to 100 ft	30 f	t to 50 ft	>150		100 ft to 150 ft	<100 ft
	-6(0) <sup>b</sup>	-4(0) <sup>b</sup> )	_	2(0) <sup>b</sup>	-2(0	))°	0	1
7. Vertical Openings	Open 4 or More	Open 2 o	r 3		Enc	losed wit	n Indicated Fire Re	sist.
	Floors Floors			<1			hr to <2 hr	≥2 hr
	-14	-10		(0	)		2(0) <sup>e</sup>	3(0) <sup>e</sup>
8. Hazardous Areas	Double	Deficiency			Single I	Deficiency	1	No Deficiencies
	In Zone	Outside Zo	one	In Zone		In A	djacent Zone	
	-11	-5		_	6		-2	(0)
9. Smoke Control	No Control	Smoke Bar Serves Zo		Mech. Assisted Systems by Zone		ems		
	-5(0)°	0		3				
10. Emergency	<2 Routes				Multipl	le Routes		
Movement Routes	_	Deficien	t		orizontal it(s)		Horizontal Exit(s)	Direct Exit(s)
	(-8)	-2			0		1	5
11. Manual Fire Alarm	No Man	ual Fire Alarm			Manua	l Fire Alar	m	
				W/O F.I	D. Conn.	V	V/F.D. Conn	
		-4			1		(2)	
12. Smoke Detection and Alarm	None	Corridor O	nly	Room	s Only	1	orridor and oit. Spaces	Total Spaces In Zone
	0(3) <sup>g</sup>	2(3) <sup>g</sup> )		3(	3) <sup>g</sup>		4	5
13. Automatic Sprinklers	None	Corridor a Habit. Spa			tire ding		н —	
	0	8		(1	0)	7		

NOTE: a Use (0) where parameter 5 is -10.

For SI units: 1 ft = 0.3048 m

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

<sup>&</sup>lt;sup>c</sup> Use (0) on floor with fewer than 31 patients (existing buildings only)

<sup>&</sup>lt;sup>d</sup> Use (0) where parameter 4 is -10.

<sup>&</sup>lt;sup>e</sup> 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.

<sup>&</sup>lt;sup>9</sup> 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 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<sub>1</sub>, S<sub>2</sub>, S<sub>3</sub>, S<sub>6</sub> to blocks labeled S<sub>1</sub>, S<sub>2</sub>, S<sub>3</sub>, S<sub>6</sub> in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS									
Safety Parameters	Containment Safety (S <sub>1</sub> )	Extinguishment Safety (S <sub>2</sub> )	People Movement Safety (S <sub>3</sub> )	General Safety (S₄)					
1. Construction	-7	-7		-7					
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		O	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	io	10 ÷2=5	10					
Total Value	<b>S</b> 1= <b>Q</b>	S2= 8	S₃= 3	<b>S</b> 4= 6					

TABLE 6. MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)								
		Containment Extinguishment People (Sa) (Sb)				lovement Sc)		
Zone Location	New	Exist.	New Exist.		New	Exist.		
1 <sup>st</sup> story 2 <sup>nd</sup> or 3rd story <sup>b</sup> 4 <sup>th</sup> story or higher	11 15 18	5 9 9	15(12) <sup>a</sup> 17(14) <sup>a</sup> 19(16) <sup>a</sup>	4 6 6	8(5) <sup>a</sup> 10(7) <sup>a</sup> 11(8) <sup>a</sup>	1 ③ 3		

a. Use ( ) in zones that do not contain patient sleeping rooms.

b. For a 2<sup>nd</sup> 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: Sa=7, Sb=10, and Sc=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 Sa, Sb, and Sc 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 EQU	IVALENCY EVALUATION	Yes	No
Containment Safety (S <sub>1</sub> )	minus	Mandatory Containment (S <sub>a</sub> )	≥ 0	$\begin{bmatrix} S_1 & S_a & C \\ q & - & Q \end{bmatrix} = \begin{bmatrix} C & O \end{bmatrix}$	/	
Extinguishment Safety (S <sub>2</sub> )	minus	Mandatory Extinguishment (S₀)	≥ 0	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	1	
People Movement Safety (S <sub>3</sub> )	minus	Mandatory People Movement (S₀)	≥ 0	S <sub>3</sub> - S <sub>c</sub> P	1	
General Safety (S <sub>4</sub> )	minus	Occupancy Risk (R)	≥ 0	$\begin{bmatrix} S_4 \\ I_6 \end{bmatrix} - \begin{bmatrix} R \\ I_6 \end{bmatrix} = \begin{bmatrix} G \\ O \end{bmatrix}$	1	

	TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET							
1	mplete one copy of this worksheet for each facility. r 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.			J				
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.	J						
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	J						
E.	There are no flue-fed incinerators.	J						
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.	7						
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	J						
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	/	VALUE - 100					
1.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	J,						
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	V.						
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	1						
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			/				

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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

Grand Avenue Rest Home May 4, 2016 Page 2

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

Kumalu Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

PRINTED: 06/23/2016 FORM APPROVED

(X6) DATE

Minnesota Department of Health

			(X3) DATE COMP	SURVEY LETED		
		00208	B. WING		04/1	8/2016
	PROVIDER OR SUPPLIER	3956 GRA	DRESS, CITY, S AND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
3 000 INITIAL COMMENTS		3 000				
	144A.10, this correct pursuant to a surver found that the deficiency herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Departments of the Minnesota MN Rumber and MN Rumber and MN Rumber and MN Rumber are comply with any of lack of compliance. re-inspection with a result in the assess that was violated ducorrected.  You may request a that may result from orders provided that the Department with	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.  The ther a violation has been compliance with all rule provided at the tag alle number indicated below. In the several items, failure to the items will be considered Lack of compliance upon my item of multi-part rule will ment of a fine even if the item uring the initial inspection was the aring on any assessments in non-compliance with these ta written request is made to be in 15 days of receipt of a				
	INITIAL COMMENT Minnesota Departm the State Licensing federal software. Ta	nent of Health is documenting Correction Orders using ag numbers have been ota state statutes/rules for				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

05/14/16 **Electronically Signed** 

TITLE

STATE FORM 6899 WCGU11 If continuation sheet 1 of 36

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COIVIE	LETED
		00208	B. WING		04/1	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	AVENUE REST HOME		ND AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
3 000	column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. The findings which are in after the statement, evidence by." Followare the Suggested Time period for Complement of the Column PROVIDER'S PLANAPPLIES TO FEDE THIS WILL APPEATHERE IS NO RECOPLAN OF CORRECOMINNESOTA STAT	umber appears in the far left Prefix Tag." The state compliance is listed in the ent of Deficiencies" column co Comply" portion of the nis column also includes the n violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and crection.  ARD THE HEADING OF THE	3 000			
3 615	MN Rule 4655.3200	the orders have been revised.  O Subp. 3 Patient or Resident	3 615			6/3/16
	Accurate, complete patient or resident f the time of dischard current and shall be at the nurses' or att	on and placement of records. e, and legible records for each from the time of admission to ge or death shall be kept e maintained in a chart holder tendants' station, a central e storage of records and				

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 2 of 36

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTIO			(X3) DATE COMP	SURVEY LETED		
		00208	B. WING		04/1	8/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME	3956 GRA	DRESS, CITY, S AND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
3 615	Continued From pa	ge 2	3 615			
	by: Based on interview facility did not ensu	and document review, the re retention of complete and ecords for 1 of 3 (R20) opeen hospitalized.		Corrected. Also disputing the info		
	Minimum Data Set dated 2/6/16, identi	o the facility on 3/23/15. A (MDS) annual assessment fied R20 as independent with ing and had intact cognition.				
	dated 8/3/15, indica making poor decision issues and was curthree times per week indicated R20 had a and was a "former ladmission has used assessment further multiple Vulnerable admission related to the recommendations of R20 could leave the medical record lack illegal drugs from the through 8/3/15) as in A note dated 12/28/	indicated that R20 had Adult (VA) issues since o poor choices. Staff on the assessment indicated a facility independently. R20's and documentation of use of the time of admission (3/23/15) dentified in the CSA.				
	admitted to having contributed to anoth emergency room. The first time that hat	nistrator revealed R20 alcohol in her room which her resident (R7) going to the he note indicated that was not ad occurred and that was a lity policy. The note further				

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 3 of 36

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00208	B. WING		04/1	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	AVENUE REST HOME		ND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
3 615	to ensure the safety residents and suggrandom room check medical record did incidents related to R20's Progress Not through 4/11/16, and On 2/3/16, at 7:30 a lethargic although a asked. R20 was given and stated "I'm just later, R20 states shifelt sick to her stor again after the nurse which stated they "unurse found resider and neck hyperexte and breathing, pulse 80/bpm [beats per not responsive-pup attendants gave Nature and resident responsive pup attendants gave Nature and resident responsive entitied. On 2/below the above entited they found a state resident admit 2/3/16, at 5:00 p.m. for heroin overdosed documentation to the suicide note in R20 R20's Hospital Discindicated R20 had provided the safety of the safety	al interventions were required of R20 and the other ested R20 was now subject to ks and a room change. R20's not identify previous dates or alcohol use.  Ites were reviewed from 1/16 of revealed the following:  a.m. resident appeared able to respond to questions if the five ounces of apple juice so thirsty." One half hour use could not eat breakfast and mach." R20 was checked se was called by roommates were worried" about R20. The nt "laying across bed with head ended. Res. [resident] warm e approx [approximately] minute] and strong. Res. just ills dilated. 911 was calledircan [a heroin reversal agent] anded and was taken to ER. The physician and family (3/16, a "Postnote" was written attry that indicated "EMTS [sic] suicide note and took it with arted any suicidal thoughts to rom 7am-3pm. EMTS [sic] titled for snorting heroin." On R20 was admitted to hospital and information regarding R20's "s medical record.	3 615			
		Itered mental status and				

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 4 of 36

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00208	B. WING		04/1	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	AVENUE REST HOME	-	ND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
3 615	Continued From pa	age 4	3 615			
	of any other recent review of R20's ME discharge summar; and an entry trackii on 1/13/16. When a discharge summar; 4/14/16, at 2:40 p.r (SWD) stated the hwith any written sumurse (LPN)-A state medication list, so the R20's labs were reviested positive for R20's medical recompliance of the positive for R20'	ord revealed no documentation hospitalization. However, a DS assessments indicated a y was completed on 1/9/16, and record MDS was completed asked about the 1/9/16 y and documentation on in. the social work designee hospital had not provided them in mary. Licensed practical ed they only needed the the rest was shredded.  Viewed which indicated R20 THC (marijuana) on 3/26/16. And did not indicate any further isitive lab result.  The SWD on 4/14/16, at 2:42 was aware of R20's heroin in the SWD was unaware if hospitalizations due to				
	with the hospital or found, which she in not a suicide note. was no documenta	D stated she had followed up the note that the EMT's adicated was a love letter and The SWD confirmed there tion of follow up in R20's but the note, however stated				
	she discussed the she "wanted to live R20's past drug us positive for marijua	incident with R20 who stated "The SWD was aware of e and stated R20 had tested na once before and confirmed ted on R20's care plan.				
	(IDON) on 4/15/16, someone at the factorial on the "sui	nterim director of nursing at 2:28 p.m. revealed cility followed up with the cide note" and found out the "love letter" and not a suicide				

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 5 of 36

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY PLETED	
7.110 1 27.11	or connection	BENTI IONI IONI NOMBELL	A. BUILDING:				
		00208	B. WING		04/1	8/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
GRAND A	AVENUE REST HOME		ND AVENUE OLIS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
3 615	note. The IDON state have been documed SUGGESTED MET director of nursing (develop a system for documentation that The director of nursing educate all approprious or designee congoing compliance TIME PERIOD FOR (21) days.	ated the information should need in R20's medical record.  CHOD OF CORRECTION: The (DON) or designee could or timely and accurate reflects the resident's status. Sing or designee could itate staff on the system. The ould monitor to ensure e.  R CORRECTION: Twenty one	3 615			6/9/16	
31130	Subpart 1. Stora medications shall be container bearing the information stating name of drug, strer expiration dates of directions for use, remained, date of origin refill, the most receaddress of the licer the medications. It the boarding care he	age in labeled containers. All e kept in their original ne original label with legible the prescription number, agth and quantity of drug, all time-dated drugs, resident's name, physician's nal issue or in the case of a nt date thereof, and name and ased pharmacy which issued shall be the responsibility of some to secure the r and name of the medication	31130			6/9/16	
	by: Based on observati review, the facility for	ent is not met as evidenced on, interview, and document ailed to ensure all medications ed with resident's names,		Corrected			

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 6 of 36

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00208	B. WING		04/1	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	AVENUE REST HOME	•	ND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
31130	Continued From pa	ge 6	31130			
	directions for use a residents (R17) tha	nd date opened for 1 of 2 t had diabetes.				
	Findings include:					
	storage observation improve blood suga plastic bag labeled	7 p.m. during the medication of a Victoza (a medication to ars) injectable pen was in a with a first name. There was or bag. There was no date				
	3/27/16, indicated F diabetes. The MDS	imum Data Set (MDS) dated R17 had a diagnosis of indicated R17 had received even out of seven days.				
	indicated R17 was	er Sheet dated 3/24/16, to receive Victoza 1.8 ection daily at noon for				
	licensed practical n had been removed but had not been us	4/12/16, at 12:07 p.m. the urse (LPN)-A stated Victoza from the refrigerator yesterday sed yet. LPN-A said, "I do not ot have a name on it or a				
	Novo Nordisk dated "Use a Victoza pen	actures package insert by d 3/9/15, instructed users, for only 30 days. Throw away after 30 days, even if some ne pen."				
	5/1/14, instructed s of the medications each resident's me	d Cart Audits policy updated taff, "To ensure the accuracy administered to the residents, dications and house audited internally by nursing				

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 7 of 36

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00208	B. WING		04/1	8/2016
	PROVIDER OR SUPPLIER AVENUE REST HOME	3956 GRA	DRESS, CITY, S AND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
31130	items to audited for 3. All medications r have a legible date becoming hard to remust discard as if it. Facility Proper Labelacked instructions label which included directions for use.  SUGGESTED MET The director of nurse develop systems to are audited on a romedications without appropriately replaced DON or designee of staff members on the designee could devensure ongoing corrections remainded to the surrections of the surrect	Policy instructed staff that included: equiring a date opened must. It is beginning to smear or ead, fix it. If it is illegible, you tis expired."  eling policy updated 5/5/12, that medications required a diresident's name and  THOD FOR CORRECTION: sing (DON) or designee could be ensure all medication areas utine basis to ensure any tan appropriate label are ced/disposed of/relabeled. The ould educate all appropriate the system. The DON or relop monitoring systems to	31130			
31145	Containers;Out of c Subp. 4. Out of Medications having	O Subp. 4 Medication date medications  date medications.  a specific expiration date fter the date of expiration.	31145			6/9/16
	by: Based on observati review, the facility f	ent is not met as evidenced ion, interview, and document ailed to ensure expired emoved from the medication		Corrected		

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 8 of 36

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3956 GRAND AVENUE SOUTH  MINNEAPOULS, MN 55409  PHEETX TAG  CALL REGULATORY OR LSC IDENTIFYING INFORMATION)  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's as to receive 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, several and the medications administered to the residents, several contents.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
CRAND AVENUE REST HOME   SUMMARY STATEMENT OF DEFICIENCIES, MN 55409   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG   PRE			00208	B. WING		04/1	8/2016
PRIEFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  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		GRAND AVENUE BEST HOME 3956 GR			SOUTH		
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	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
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	cart.  Findings include:  On 4/12/16, at 7:04 storage observation was observed to be top drawer of the m with R1's name and and expired on 4/12 the opened date. Lf expired 28 day afte  R1's annually Minim 2/20/16, indicated F diabetes. The MDS insulin injections se  The Physician Orderindicated R1 was to at bedtime for diabeted T/15, indicated the expiration date adays after you first the expiration date adays after you first the responsibility  Facility Internal Med 5/1/14, instructed stof the medications will be every two weeks." Fitems to audited for "2. Check for and resident of the medication of the medication of the medication of the medications will be every two weeks." Fitems to audited for "2. Check for and resident of the medication of the medicati	p.m. during medication one vial of Lantus (insulin) estored ready for use in the redication cart that was labeled dated as opened on 3/14/16, 2/16. That was 30 days from PN-B verified the Lantus rebeing opened.  The Data Set (MDS) dated R1 had a diagnosis of indicated R1 had received even out of seven days.  The Sheet dated 3/24/16, or receive Lantus 15 units daily etes.  The Sheet dated 3/24/16, or receive Lantus 15 units daily etes.  The Sheet dated 3/24/16, or receive Lantus 15 units daily etes.  The Sheet dated 3/24/16, or receive Lantus 15 units daily etes.  The Sheet dated 3/24/16, or receive Lantus 15 units daily etes.  The Cart Sheet dated 3/24/16, or receive Lantus 15 units daily etes.  The Sheet dated 3/24/16, or receive Lantus 15 units daily etes.  The Cart Sheet dated 3/24/16, or receive Lantus 15 units daily etes.  The Cart Sheet dated 3/24/16, or receive Lantus 15 units daily etes.  The Cart Audits policy updated taff, "To ensure the accuracy administered to the residents, dications and house audited internally by nursing Policy instructed staff that included: emove expired medications.	31145			

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 9 of 36

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY MPLETED	
		00208	B. WING		04/18	8/2016
	NAME OF PROVIDER OR SUPPLIER  GRAND AVENUE REST HOME  STREET AD  3956 GRA  MINNEAP					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETE DATE
31145	procedures. 3. All medications rehave a legible date. becoming hard to remust discard as if it  SUGGESTED MET The director of nurse develop systems to are audited on a roumedications withou the expiration date replaced/disposed designee could edumembers on the sy could develop moniongoing compliance.	equiring a date opened must It is beginning to smear or ead, fix it. If it is illegible, you is expired."  THOD FOR CORRECTION: sing (DON) or designee could ensure all medication areas utine basis to ensure any t an expiration date or beyond are appropriately of/relabeled. The DON or cate all appropriate staff stem. The DON or designee toring systems to ensure	31145			
31895	of HCF Bill of Right Subd. 23. Serv and residents shall for the facility unles for therapeutic purp goal-related in their  This MN Requirement by: Based on observati	ices for the facility. Patients not perform labor or services s those activities are included loses and appropriately individual medical record.  ent is not met as evidenced on interview and document	31895	Corrected. Also disputing the information order.		5/23/16
	(R17, R13) in the safet for the facility, did s	ailed to ensure 2 of 2 residents ample who performed services o according to an established I at a prevailing rate.		that triggered this correction order.		

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 10 of 36

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00208	B. WING	<del></del>	04/1	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	AVENUE REST HOME		AND AVENUE POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
31895	Continued From pa	ge 10	31895			
	Findings include:					
		at 6:05 p.m. on 4/12/16, or 15 residents in the dining				
	R17 stated she workitchen passing out also stated she was gone from 25 dollar week, because the person in the kitchereceived a payched she passed out the paid cash. R17 also out on weekends. Finad" her pay had interview with R17 out	d at 3:27 p.m. on 4/14/16. Red one hour a day in the trays to the residents. She is upset because her pay had its a week, to 15 dollars a facility had hired a new staff en. When asked whether she k from the facility, R17 said trays Monday-Friday and was a stated R13 passed the trays R17 again stated she was gone down. During a follow up on 4/15/16, at 10:49 a.m., R17 every other Monday.				
	a.m. on 4/15/16, an schedule of when F the dining room. Th	er was interviewed at 10:30 d produced a calendar R17 and R13 passed trays in the dietary manager stated she ts had volunteered and stated for ten minutes.				
		ttempts were made to ever, R13 was unavailable.				
	plan dated 10/20/15 either resident to he plans for both resid resident was perfor whether the resider	ed 10/6/15, and R13's care 5, were void of any plan for elp in the kitchen. The care ents lacked any evidence the ming services for the facility, at was getting paid for the ner the resident had agreed to ent.				

Minnesota Department of Health STATE FORM

WCGU11 If continuation sheet 11 of 36

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00208	B. WING		04/1	8/2016
	PROVIDER OR SUPPLIER  AVENUE REST HOME	3956 GRA	DRESS, CITY, S IND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
31895	Continued From pa	ge 11	31895			
	3/14/16, going forwineither resident was neither resident was for Meal Set Up dathad signed. R17 has and R13 had signed indicated the reside meal set-up, would and would follow inform lacked any incresident was being any plan for their he individualized plans. On 4/15/16, at 4:15 designee (SWD) ar interviewed. The SV residents had come both were either pathe services render verified R17's and Farrangement, and the were not document. Suggested Method nursing (DON) or dwas a system in platwork for the facility assessment, care pstatus. The DON or staff are aware of the procedures. The DO and R17 in R18 in	p.m. the social worker and administrator were ND acknowledged the to her to ask for jobs and that id cash, or with gift cards, for ed in the kitchen. The SWD R13's desire to work, work he assigned kitchen duties ed on their plans of care.  of Correction: The director of esignee could ensure there are to ensure no resident's				
	compliance.  TIME PERIOD FOR (21) days	R CORRECTION: Twenty One				

Minnesota Department of Health STATE FORM

6899 WCGU11 If continuation sheet 12 of 36

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				<del></del> .		
		00208	B. WING		04/1	8/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRAND A	AVENUE REST HOME	•	ND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	HOULD BE COMPLE	
31990	immediately make a entry point. Use of for the deaf or othe considered an oral point may not requi extent possible, the content to identify the content to identify the caregiver, the natur maltreatment, any emaltreatment, the maltreatment, the maltreatment, the maltreatment, the maltreatment, and any of reporter believes maltreporter may disclosin section 13.02, and section 144.335, to comply with this sulfaction. This MN Requirements with abuse, injurite elopement, substantand/or falls with signesidents (R20, R7, Findings include:  R20 was admitted the minimum data set (dated 2/6/16 identification).	Inerable Adults  Ing. A mandated reporter shall an oral report to the common a telecommunications device r similar device shall be report. The common entry re written reports. To the report must be of sufficient he vulnerable adult, the re and extent of the suspected evidence of previous name and address of the date, and location of the ther information that the right be helpful in investigating reatment. A mandated se not public data, as defined and medical records under the extent necessary to odivision.  The port allegations of the suspected and medical records under the extent necessary to odivision.	31990	Corrected. Also disputing some of information that triggered this corrorder.		6/9/16
	R20's Community S	Safety Assessment dated				

6899

Minnesota Department of Health STATE FORM

WCGU11 If continuation sheet 13 of 36

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00208	B. WING		04/1	8/2016
-	PROVIDER OR SUPPLIER  AVENUE REST HOME	3956 GR	DRESS, CITY, S AND AVENUE POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
31990	8/3/15 indicated that history of substance making, and was cuthree times per wee indicated "since addrugs". The assess had multiple vulners admission related to recommendations of R20 could leave the A note dated 12/28/signed by the admit admitted to having contributed to anoth emergency room. Twas not the first time R20's progress note 1/16-4/11/16 and re R20 was found to be Emergency Medica activated, the reside (medication which resuch as Heroin) and emergency room. Ferrom Hospital Discharge indicated that R20 to for altered mental soverdose.  R20's Mental Health 3/5/16-4/5/16 indicated that R20 to for altered mental soverdose was suspended and suse" and staff had overdose was suspended with anotamily member and	at R20 had an extensive abuse, poor decision arrently attending treatment ex. The assessment further mission has used illegal ment further identified R20 able adult (VA) issues since a poor choices. Staff on the assessment indicated a facility independently.  The in R20's medical record instrator revealed that R20 alcohol in her room which her resident (R7) going to the he note indicated that this e this has occurred.  The swere reviewed from evealed on 2/3/16 at 7:30 a.m. the lethargic and unresponsive. I Services (EMS) were ent was provided Narcan everses some overdoses of transported to the R20 was admitted. R20's Summary dated 2/8/16 was admitted to the hospital tatus and accidental heroin	31990			

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 14 of 36

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00208	B. WING		04/1	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	AVENUE REST HOME		AND AVENUE POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
31990	identified a history of heroin overdose and now had and order.  Interview with the S on 4/14/16 at 2:42 paware of R20's hero SWD was unaware hospitalizations due asked if R20's hero hospitalization was The SWD replied the tobe reported, ever flow chart".  Interview with the Ir (IDON) on 4/15/16 awas the nurse work was aware of R20's unaware why R20 worning. The IDON with R20 having any drug use prior to 2/3 drugs in the facility. should be reported replied "I don't know R7 was admitted to diagnoses that includisorder, schizophra R7's Minimum Data assessment dated was intact and was daily living.  R7's careplan dated adult (VA) issues of behavior and chemidecisions. The care	of heroin addiction-recent d indicated that the facility for Narcan.  ocial Worker Designee (SWD) o.m. revealed that she was bin overdose on 2/3/16. The if R20 had any other to overdose. The SWD was in overdose with reported to the state agency. The incidents were "not required in if hospitalized. We follow a sterim Director of Nursing at 2:28 p.m. revealed that she ing on 2/3/16 and stated she is previous drug use but was was unresponsive that a stated she was not familiar y similar incidents related to 3/16 was not aware of any When asked if this incident to the state agency the DON				

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 15 of 36

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00208		B. WING		04/18/2016	
GRAND AVENUE BEST HOME 3956 GRA			ORESS, CITY, S IND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
31990	consumed alcohol to R7's progress notes 10/21/15-4/11/16 ar 9:11 p.m. R7 was founable to sit up in both was called and R7 hospital. She return got the alcohol from R17. An emergency admission sheet dath that R7 was hospital R7's social service reviewed and indicated worker designee (South edrinking inciden R7 got angry and so R7's medical record appointment referratingly included the note that was hidden in the An interview with the 4/14/16, at 4:03 p.m familiar with R7's characteristic was an ongoing problem on the care administrator confirmed it was an ongoing problem on the care administrator confirmesulting hospitalizate state agency. The sincident was "not rehospitalized" and the	chat resulted in hospitalization.  So were reviewed from and revealed on 12/27/15 at bound with a "blank stare led" and slurred speech. 911 was transported to the led 12/28/15. R7 reportedly in her roommates R20 and of department hospital led 12/17/15 which indicated alized for alcohol intoxication.  Progress notes were also lated on 1/4/16 the social WD) spoke with R7 regarding the and resulting hospitalization. Creamed "that was not me".  It included a psychial lated 1/11/16 which lated R7 was hospitalized for Roommate gave her alcohol	31990			

6899

Minnesota Department of Health STATE FORM

WCGU11 If continuation sheet 16 of 36

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00208	B. WING		04/1	04/18/2016	
NAME OF	PROVIDER OR SUPPLIER		INDESS CITY S	TATE ZID CODE	1 0.7.	10/2010	
NAME OF	PROVIDER OR SUPPLIER		ND AVENUE	TATE, ZIP CODE			
GRAND	AVENUE REST HOME	•	POLIS, MN 55				
(V4) ID	SLIMMARV STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	COMPLETE DATE	
31990	Continued From pa	ge 16	31990				
	(IDON) on 4/15/16	e Interim Director of Nursing at 2:28 p.m. revealed she reported the incident to "where d to".					
	R16 was accepted 11/9/15, under com dependency. The M dated 12/7/15, indicintact, mildly depressymptoms directed care daily. The Care Area Assindicated R16 was medications for anx The undated care pmissing person repfacility at specified teaves of absence (medications. Nursing progress manual progress of the was found to be resident was taken ambulance. The hoof 0.37. On 11/18/1 had been admitted R16 returned to the On 12/8/15, at 10:0	and admitted to the facility mitment for chemical finimum Data Set (MDS) cated R16 was cognitively seed, had verbal behavioral towards others, and rejected essment (CAA) dated 12/7/15, receiving anti-psychotic ciety and verbal aggression. Dan identified R16 had one ort for failure to return to time. R16 was able to have (LOA's) and self administer otes on 11/17/15, at 6:00 p.m. te lethargic and confused. The to the emergency room via spital reported an alcohol level 5, it was documented that R16 to the hospital. On 11/24/15, a facility.					
	medications throug be back at 10:00 p. through her boyfried facility until 12/15/12 why she didn't return had some things I had some things I had some R16 was noncompled long history of alcoholege, treat	with her boyfriend. She had h bedtime. She stated she will m. Although contacted and, R16 did not return to the 5 at 5:30 p.m. When asked in for a week, R16 replied "I had to take care of." mary dated 12/9/15, indicated: iant with medications, had a nol use and multiple chemical tment programs and long nousing. R16 was currently					

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 17 of 36

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00208	B. WING		04/1	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	AVENUE REST HOME		ND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
31990	getting alcohol from favors. On 12/25/15, R16 wand medications. R that evening. On 12 called the facility to emergency room ar pneumonia. The facility to emergency room ar pneumonia. The facility for extended time worder for no overnig On 4/14/16, at 2:42 (SWD) and adminis for resident LOA's. residents "Sign LOThe SWD stated the assessment and on medication asse	went on LOA with her boyfriend 16 stated she would be back 1/26/15, at 6:45 p.m. R16 inform them she was at the nd was being admitted for cility verified this with the ER of nursing (IDON) 's hand scharge/Summary Information of alcohol, left premises without notice. Broke court lefts outside of facility." p.m. the social work designee strator were asked for policies The SWD stated the A form and ask for meds." ey complete one community the self administration of ment. If a resident did not ng, she would utilize the	31990			

6899

Minnesota Department of Health STATE FORM

WCGU11 If continuation sheet 18 of 36

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00208	B. WING		04/1	04/18/2016	
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 04/1	0/2010	
		3956 GRA	IND AVENUE				
GRAND	AVENUE REST HOME	MINNEAP	OLIS, MN 5	5409			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
31990	The facility's policy Maltreatment Preversindicated that the fat form of maltreatment of physical, verbal, form of neglect, inversion punishment or mish. The policy also inclusion and potentially dangerous safety and approach	entitled "Vulnerable Adult ention Plan" dated 3/6/15, acility "does not tolerate any nt" which included "any form mental or sexual abuse; any oluntary seclusion, corporal randling of resident property". Aded the following: will be made of a prospective mission for a known history of the second s	31990				
		is responsible to report all and suspected crimes to					
	she was cognitively with all activities of dated 2/23/16 ident and indicated no vu	num Data Set (MDS) indicated intact and was independent daily living. R14's care plan ified her as a vulnerable adult linerable adult issues.					
		progress notes indicated in een called a derogatory name					

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 19 of 36

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00208	B. WING		04/1	8/2016	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GRAND	AVENUE REST HOME		AND AVENUE POLIS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
31990	Continued From pa	ge 19	31990				
	day. The noted indi upsetting" to R14. A indicated R14 had derogatory names	in the facility three times that cated "this incident was very A progress note dated 4/12/16 complained of being called by another resident "qday" tated it had happened as vious 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.						
	2/5/16, indicated Redelusions (fixed falsindependent with a dressing and persoindicated R6 was u	mum Data Set (MDS) dated 6 was cognitively intact with se beliefs) and was Il activities of daily living except nal hygiene. The MDS also nsteady when going from or turning around, did not use					

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 20 of 36

STATEMENT OF D		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00208	B. WING		04/1	8/2016
NAME OF PROVID	ER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
GRAND AVENU	JE REST HOME		ND AVENUE OLIS, MN 5			
	EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
any ribreati diagrischizi retari 4/14/ R6's vulne and issue "Fx [inge it hap obse smoked and obse smoked and obse smoked and issue and i	th with walking noses of anem cophrenia. Dia dation noted of 15.  care plan date erable adult an 2/16/16, indicasts. 12/23/15, te fracture]. of progrece (etiology unk opened)"  ervation on 4/1 valking without he smoking room. At 1 rved to stumbly king room.  ew of Incident/ 15, at 11:29 a. sp [after] being all puffy and 2 spht] eye. She diened." Type of sion, and swell did not know vent did not rendent report did ate agency were served and 15, at 12:00 p. ent] fell against t], has a swolled.	ge 20 s and that R6 became short of R6's MDS indicated R6 had ia, diabetes, hypertension, and gnosis of mild mental office visit note dated  d 8/26/15, identified R6 as a docomments dated 11/16/15, ated no vulnerable adult emporary care plan problem oximal phalanx of L [left] 5th nown-res does not know how  3/16, at 11:40 a.m. identified a cane, limping and stumbling om. R6 fell into a chair in the 2:41 p.m. R6 was again e and fall into chair in the  Accident Report dated m. indicated "Pt woke up-few up we noticed her R [right] sm [small] lacerations around oes not remember how it injury listed as "hematoma, ing." Incident form indicated when injury happened and nember falling. Incident I not indicate the administrator re informed of the injury.  I Progress Notes dated m. indicated: "Appears pt something during the noce of right eye under each eye rations are 3 mm [millimeters]	31990			

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 21 of 36

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00208	B. WING		04/1	18/2016	
NAME OF PROVIDER OR SUPPLIER  GRAND AVENUE REST HOME	3956 GRA	DRESS, CITY, S IND AVENUE OLIS, MN 58				
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
[complaining of] (unrestates hit head on do to help guide her." R 4/21/15 through 4/27/administrator or SA wunknown origin.  Nurses Record and F 12/23/15 at 1:30 p.m. office and showed nuncted bruising on the minor swelling. R6 w Physician's Progress indicated R6 is in clin bruising and swelling not remember hitting note indicated X-ray sphalanx of left fifth fin orthopedic follow up werecommended.  The Serious Injury Rethe Office of the Omband Mental Retardations sustained an fracture hand. Description of indicated "resident do happened. Nurse obsof left hand." The seconotified including med Facility Complaints - sprotection were blank.  At time of the injury Fhappened. While the	at 3:00 p.m"is now c/o eadable) w c/o headache. For going to BR-has flashlight leview of progress notes /15, did not indicate the were notified of the injury of  Progress Notes dated . indicated R6 came into urse her left hand. Nurse front and back of hand with was sent to urgent care.  Notes dated 12/23/15, sic for assessment of of left hand and that R6 did hand or banging it. Progress showed fracture of proximal nger splint placed and with in next week  eport dated 12/23/15, sent to budsman for Mental Health on, indicated R6 had e of the fifth finger of the left how the injury happened bes not know what served swelling and bruising ction triggering others to be dical, OHFC [Office of Health state agency] and adult	31990				

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 22 of 36

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00208	B. WING		04/1	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	AVENUE REST HOME	•	ND AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
31990	Continued From pa	ge 22	31990			
	agency was notified unknown origin.	d of the significant injury of				
	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.					
	Licensed practical r document notifying fracture we do not r weekend or nights	4/15/16, at 9:25 a.m. nurse (LPN)-A said "We do not the administrator. If there is a notify administrator on the because we have dealt with it. admitted to the hospital we w."				
	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."					
	administrator said,	4/15/16, at 2:15 p.m. the "I ask them to chart notifying to notify me about fractures."				
	interim director of n facility reported inju Reporting fractures we know where the said, "If there have is not reportable. W supposed to." Whe injuries of unknown	4/15/16, at 2:19 p.m. the surses (IDON) stated, the cries of unknown origin. depended on whether or not resident had been. The IDON not been any incidents then it be report to where ever we are n asked about reporting origin to the state agency the ombudsman the IDON				

Minnesota Department of Health

STATE FORM 6899 WCGU11 If continuation sheet 23 of 36

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BUILDING:			
		00208	B. WING		04/1	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	AVENUE REST HOME		ND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
31990	Continued From pa	ge 23	31990			
	said, "I have always reported to the same place."					
	administrator or desto ensure potential abuse/neglect/misa allegations are reported administrator and sor designee could esystem. The adminensure ongoing corrollation of the period of	THOD OF CORRECTION: The signee could develop systems appropriation of funds orted immediately to the tate agency. The administrator educate all staff om this istrator could monitor to appliance.  R CORRECTION: Twenty One				
	(21) days					
32000	MN Rule 626.557 S Maltreatment of Vu		32000			6/9/16
	Subd. 14. Abuse	e prevention plans.				
	and personal care a shall establish and abuse prevention p assessment of the environment, and it which may encoura statement of specif minimize the risk of	s population identifying factors ge or permit abuse, and a ic measures to be taken to abuse. The plan shall comply rning the plan promulgated by				
	agency and person providers, shall dev prevention plan for there or receiving s shall contain an ind	ncluding a home health care all care attendant services relop an individual abuse each vulnerable adult residing ervices from them. The plan ividualized assessment of: (1) eptibility to abuse by other				

Minnesota Department of Health STATE FORM

6899 If continuation sheet 24 of 36 WCGU11

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00208	B. WING		04/1	8/2016
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
GRAND	AVENUE REST HOME		ND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
32000	the person's risk of adults; and (3) state measures to be tak abuse to that person For the purposes of "abuse" includes see (c) If the facility, and personal care a knows that the vuln violent crime or an toward others, the inplan must detail the minimize the risk the reasonably be expendicility and persons unsupervised. Undo for a vulnerable adult misconduct or physical such information from the facility is ongoing another facility, and the facility is ongoing vulnerable adult.	g other vulnerable adults; (2) abusing other vulnerable ements of the specific en to minimize the risk of n and other vulnerable adults. If this paragraph, the term	32000			
	by: Based on observati review, the facility f policy for reporting injuries of unknown abuse within the fac	on, interview and document ailed to operationalize their of allegations of verbal abuse, origin, elopement, substance cility, and/or falls with 5 of 17 residents (R20, R7,		Corrected.		
	Findings include:					
	The facility's policy	entitled "Vulnerable Adult				

6899

Minnesota Department of Health STATE FORM

WCGU11 If continuation sheet 25 of 36

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED		
	00208	B. WING		04/1	8/2016
NAME OF PROVIDER OR SUPPLIEF	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
GRAND AVENUE REST HOM	<b>-</b>	AND AVENUE			
OVO ID CHMMADV CI		POLIS, MN 55	PROVIDER'S PLAN OF CORRECT	ION	()/5)
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
32000 Continued From p	age 25	32000			
indicated that the form of maltreatm of physical, verbal form of neglect, in punishment or mis The policy also inc -" An assessment resident prior to ac potentially dangere -"Individual suscer included in the own with goals and appropriate administrator mus -"The administrator mus -"The administrator flowchart to deterring requirements"Nursing complet whish [sic] is a col needs to be subm Administrator subm Minnesota Departicavailable" -"You must make you will administrator imm safety. The facility reportable incident MDH".  Based on observation review, the facility verbal abuse, injury elopement, substationally and/or falls with sit residents (R20, R20).  R20 was admitted minimum data set	rention Plan" dated 3/6/15, facility "does not tolerate any ent" which included "any form, mental or sexual abuse; any voluntary seclusion, corporal shandling of resident property". Sluded the following: will be made of a prospective dmission for a known history of bus behavior patterns" or otibility will be assessed and erall resident careplan along proaches for prevention and as suspected or observed the tole notified immediately". For or representative will use the mine the reporting forms lection of information that itted to MDH online. The mits the online report to the ment of Health immediately as your report directly to the facility ediately after ensuring resident of is responsible to report all the sand suspected crimes to tion, interview and document failed to report allegations of ries of unknown origin, ance abuse within the facility, gnificant injury for 6 of 17 of R16, R14, R6, R8).  To the facility on 3/23/15. A (MDS) annual assessment ified R20 as independent with				

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 26 of 36

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING.				
		00208	B. WING	····	04/1	8/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GRAND A	AVENUE REST HOME		AND AVENUE POLIS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
32000	R20's Community S 8/3/15 indicated that history of substance making, and was contree times per week indicated "since addrugs". The assess had multiple vulners admission related to recommendations of R20 could leave the A note dated 12/28/signed by the admit admitted to having contributed to anoth emergency room. The was not the first time R20's progress note 1/16-4/11/16 and referency Medical activated, the reside (medication which is such as Heroin) and emergency room. Hospital Discharge indicated that R20 of reference mental soverdose.  R20's Mental Healt 3/5/16-4/5/16 indicated that R20 of altered mental soverdose was suspense.	ing and intact cognition.  Safety Assessment dated at R20 had an extensive endouse, poor decision currently attending treatment ext. The assessment further mission has used illegal ment further identified R20 able adult (VA) issues since to poor choices. Staff on the assessment indicated endouble facility independently.  In R20's medical record mistrator revealed that R20 alcohol in her room which the resident (R7) going to the resident (R7) going to the remainder that has occurred.  In Services (EMS) were the enthus provided Narcan reverses some overdoses of transported to the R20 was admitted. R20's Summary dated 2/8/16 was admitted to the hospital status and accidental heroin	32000				

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 27 of 36 WCGU11

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLI	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
GRAND AVENUE REST HOME  3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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  3956 GRAND AVENUE SOUTH MINNEAPOLIS, MN 55409  PROVIDER'S PLAN OF CORRECTION (X5) COMPLIANCE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  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			00208	B. WING		04/1	8/2016
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  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  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  32000	GRAND	AVENUE REST HOME					
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	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	JLD BE	(X5) COMPLETE DATE
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 morring. 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	altercation with and family member and monitored by staff". identified a history of heroin overdose an now had and order. Interview with the Ston 4/14/16 at 2:42 paware of R20's herosyltalizations due asked if R20's herothospitalization was The SWD replied the tobe reported, ever flow chart."  Interview with the Ir (IDON) on 4/15/16, was the nurse work was aware of R20's unaware why R20 morning. The IDON with R20 having and drug use prior to 2/drugs in the facility. should be reported replied "I don't know R7 was admitted to diagnoses that includisorder, schizophr R7's Minimum Data assessment dated was intact and was daily living.	other resident and resident's laneeds to be closely. R20's careplan dated 3/3/16 of heroin addiction-recent addindicated that the facility for Narcan.  Social Worker Designee (SWD) p.m. revealed that she was oin overdose on 2/3/16. The extra the too overdose on 2/3/16. The extra the too overdose with reported to the state agency. The sum overdose with reported to the state agency. The incidents were "not required in the hospitalized. We follow a naterim Director of Nursing at 2:28 p.m. revealed that she sing on 2/3/16 and stated she is previous drug use but was was unresponsive that a stated she was not familiar y similar incidents related to 3/16 was not aware of any when asked if this incident to the state agency the DON w.  The facility on 9/30/14 with the ded but not limited to mood denia, and alcohol dependency. The set (MDS) quarterly review 1/5/16 indicated R7's cognition independent with activities of the state of the s	32000			

Minnesota Department of Health

STATE FORM 6899 WCGU11 If continuation sheet 28 of 36

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00208	B. WING		04/1	8/2016
GRAND AVENUE REST HOME 3956 GRA			DRESS, CITY, S IND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
32000	behavior and chem decisions. The care facility dated the care consumed alcohol in the consumed and R7 in the consumed and R7 in the consumer and in the consumer alcohol in th	ical use making poor plan identified 12-28-16 (sicre plan as the year 2016) R7 that resulted in hospitalization. It was revealed on 12/27/15 at pund with a "blank stare ped" and slurred speech. 911 was transported to the ped 12/28/15. R7 reportedly in her roommates R20 and y department hospital ped 12/17/15 which indicated alized for alcohol intoxication.  It progress notes were also perfect on 1/4/16 the social perfect on 1/4/16 the social perfect on 1/4/16 the social perfect on 1/4/16 which perfect on 1/1/16 which perfect on 1	32000			

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 29 of 36

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					ATE SURVEY DMPLETED	
		00208	B. WING	·····	04/	18/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AF	DRESS CITY S	TATE, ZIP CODE		
		3956 GB	AND AVENUE			
GRAND	AVENUE REST HOME		POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API	OULD BE	(X5) COMPLETE DATE
				DEFICIENCY)		
32000	Continued From pa	ge 29	32000			
	chart for reporting cagency.	of incidents to the state				
	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.					
	R16 was found to b resident was taken ambulance. The ho of 0.37. On 11/18/19 had been admitted R16 returned to the On 12/8/15, at 10:0 and spend the day medications through be back at 10:00 p. through her boyfrier facility until 12/15/19 why she didn't retur had some things I h Mental Health Sum	O R16 left via taxi to the doctor with her boyfriend. She had he bedtime. She stated she will m. Although contacted and, R16 did not return to the 5 at 5:30 p.m. When asked n for a week, R16 replied "I				

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 30 of 36

-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00208	B. WING		04/1	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GRAND	AVENUE REST HOME		ND AVENUE			
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
32000	Continued From pa	ge 30	32000			
	long history of alcohole dependencies, treat history of unstable it getting alcohol from favors.  On 12/25/15, R16 wand medications. R that evening. On 12 called the facility to emergency room an pneumonia. The facility to emergency room an pneumonia. The facility identified "Consumptor extended time worder for no overnig On 4/14/16, at 2:42 (SWD) and administor resident LOA's. residents "Sign LOThe SWD stated the assessment and on medication asse	nol use and multiple chemical timent programs and long housing. R16 was currently in her boyfriend in exchange for went on LOA with her boyfriend 16 stated she would be back 1/26/15, at 6:45 p.m. R16 inform them she was at the ind was being admitted for cility verified this with the ER of nursing (IDON) 's hand scharge/Summary Information potion of alcohol, left premises without notice. Broke court in the social work designee strator were asked for policies. The SWD stated the A form and ask for meds."  They complete one community in the self administration of ment. If a resident did not				

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 31 of 36

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00208	B. WING		04/1	8/2016
GRAND AVENUE REST HOME 3956 GRA			ORESS, CITY, S ND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
32000	R14 quarterly Mining she was cognitively with all activities of dated 2/23/16 idention and indicated no vull. A review of facility processed of the state of whether it's happening "reporting to the state of whether it's happening "reporting to the state of what's is not reporting to the state of the state of the state of what's is not reporting to the state of whether it's happening "reporting to the state of what's is not reporting is not reporting to the state of whether it's is not reporting is not reporting to the state of whether it's is not reporting is not reporting in the state of whether it's is not reporting is not reporting is not reporting in the state of whether it's is not reporting in the state of the stat	num Data Set (MDS) indicated intact and was independent daily living. R14's care plan ified her as a vulnerable adult ilnerable adult issues.  Progress notes indicated in een called a derogatory name in the facility three times that cated "this incident was very a progress note dated 4/12/16 complained of being called by another resident "qday" tated it had happened as vious day.  On 4/12/16, at 4:26 p.m., R14 ident in the house is "nasty" to stated another resident beat 14 stated the staff is aware of o one did anything about it.  Int interview on 4/14/16, at atted another resident in the ime and is "bossy" and "hard on 4/15/16, at 2:15 p.m. the ee (SWD) stated she was dling and reporting potential llegations. She stated when a rns she would talk to the other "you have to separate ing, or if it is their perception g." The SWD further stated, atte agency isn't always the diverbal aggression between nortable to the state agency equently" but are not an actual	32000			

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 32 of 36

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00000	B. WING		04/4	0/0016
		00208			04/1	8/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRAND	AVENUE REST HOME		ND AVENUE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
32000	Continued From pa	ige 32	32000			
	R6's quarterly Minir 2/5/16, indicated R6 delusions (fixed fals independent with a dressing and perso indicated R6 was u sitting to standing cany mobility device breath with walking diagnoses of anem schizophrenia. Dia retardation noted o 4/14/15.	mum Data Set (MDS) dated 6 was cognitively intact with se beliefs) and was II activities of daily living except nal hygiene. The MDS also nsteady when going from or turning around, did not use and that R6 became short of . R6's MDS indicated R6 had ia, diabetes, hypertension, and gnosis of mild mental n office visit note dated				
	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)"					
	R6 walking without into the smoking ro smoking room. At 1	3/16, at 11:40 a.m. identified a cane, limping and stumbling om. R6 fell into a chair in the 2:41 p.m. R6 was again e and fall into chair in the				
	4/21/15, at 11:29 a. hours p[after] being eye all puffy and 2 s R [right] eye. She dhappened." Type of abrasion, and swell staff did not know wresident did not ren	Accident Report dated m. indicated "Pt woke up-few g up we noticed her R [right] sm [small] lacerations around oes not remember how it f injury listed as "hematoma, ling." Incident form indicated when injury happened and nember falling. Incident I not indicate the administrator				

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 33 of 36

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7. BOILDING.			
		00208	B. WING		04/1	8/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GRAND AVENUE REST HOME			AND AVENUE POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
32000	or state agency were Nurses Record and 4/21/15, at 12:00 p. [patient] fell against [night], has a swolle and two small lacer long around eye." "fell against."  Note dated 4/21/15 [complaining of] (ur States hit head on to help guide her." 4/21/15 through 4/2 administrator or SA unknown origin.  Nurses Record and 12/23/15 at 1:30 p. office and showed in noted bruising on the minor swelling. R6  Physician 's Progre indicated R6 is in complete to the control of the control of the control of the complete the complete follow up recommended.  The Serious Injury the Office of the Orand Mental Retards sustained an fracture hand. Description of the control of the con	re informed of the injury.  If Progress Notes dated a.m. indicated: "Appears pt a something during the nocen right eye under each eye rations are 3 mm [millimeters]. Does not remember what she are adable) w c/o headache. It door going to BR-has flashlight Review of progress notes are notified of the injury of a Progress Notes dated are indicated R6 came into nurse her left hand. Nurse he front and back of hand with was sent to urgent care.  It is Notes dated 12/23/15, linic for assessment of any of left hand and that R6 did not hand or banging it. Progress y showed fracture of proximal finger splint placed and				

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 34 of 36

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00208	B. WING		04/1	8/2016
NAME OF I				STATE, ZIP CODE		
GRAND	GRAND AVENUE REST HOME 3956 GRA MINNEAP					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
32000	Continued From pa	ge 34	32000			
	notified including m	ection triggering others to be edical, OHFC [Office of Health - state agency] and adult nk.				
	happened. While the was notified there w	R6 was unable to state what the Office of the Ombudsman was no evidence that the state of the significant injury of				
	social worker desig for R6 was reporte	4/14/16, at 10:25 a.m. the nee (SWD) stated the injury d to the ombudsman's office agency because they were not ues.				
	Licensed practical r document notifying fracture we do not r weekend or nights l	4/15/16, at 9:25 a.m. nurse (LPN)-A said "We do not the administrator. If there is a notify administrator on the because we have dealt with it. admitted to the hospital we w."				
	SWD said "I don't the administrator be adult issue, it was a would need to know vulnerable adult iss	4/15/16, at 9:27 a.m. the hink they would bother calling ecause it was not a vulnerable a serious injury. [Administrator] v about fractures if it were a ue like the fracture was due to ot need to know if it is due to a				
	administrator said,	4/15/16, at 2:15 p.m. the "I ask them to chart notifying to notify me about fractures."				
1		4/15/16, at 2:19 p.m. the turses (IDON) stated, the				

Minnesota Department of Health

STATE FORM WCGU11 If continuation sheet 35 of 36

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00208	B. WING		04/1	8/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 01/1	0,2010
GRAND	AVENUE REST HOME		ND AVENUE			
	T	MINNEAP	OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
32000	facility reported inju Reporting fractures we know where the said, "If there have is not reportable. W supposed to." Whe injuries of unknown versus the office of said, "I have always SUGGESTED MET administrator or des to ensure the abuse operationalized. The could educate all st administrator could compliance.	ries of unknown origin. depended on whether or not resident had been. The IDON not been any incidents then it report to where ever we are en asked about reporting origin to the state agency the ombudsman the IDON reported to the same place."  THOD OF CORRECTION: The signee could develop systems eneglact plan/policy is administrator or designee aff om this system. The monitor to ensure ongoing  R CORRECTION: Twenty One	32000			

6899

Minnesota Department of Health STATE FORM