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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WP7I

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00164

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245242**
2.STATE VENDOR OR MEDICAID NO.
(L2) **159540700**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS**
(L4) **1007 EAST 14TH STREET**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/10/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **268** (L18)
13.Total Certified Beds **268** (L17)

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

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

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

* Code: **A, 5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	268			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Douglas Stevens, HFE NEII 08/19/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/19/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/11/2016
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5242

On August 10, 2016, a Post Certification Revisit (PCR) was completed by the Minnesota Department of Health and on August 4, 2016 a PCR was completed by the Minnesota Department of Public Safety to verify the facilty achieved and maintained compliance with federal deficiencies issued pursuant to the June 127, 2016 standard survey. Based on our reivisit we have deteremined the facility has achieved compliance, effective, July 27, 2016.

Further, the Documentation supporting the facility's request for a continuing waiver involving K0067 was previously forwarded to the CMS Region V Office for final detemination. Approval of the waiver request had been recommended.

Refer to the CMS 2567b forms for both health and life safety code.

Effective July 27, 2016, the facility is certified for 268 skilled nursing facility beds.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245242

September 19, 2016

Ms. Jean Cole, Administrator
Augustana Health Care Center Of Minneapolis
1007 East 14th Street
Minneapolis, Minnesota 55404

Dear Ms. Cole:

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

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

Effective July 27, 2016 the above facility is certified for:

268 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 268 skilled nursing facility beds.

We have recommended CMS approve the waiver that you requested for the following Life Safety Code Requirements: K67. If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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

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

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

Sincerely,

Mark Meath

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

Electronically delivered

August 19, 2016

Ms. Jean Cole, Administrator
Augustana Health Care Center Of Minneapolis
1007 East 14th Street
Minneapolis, MN 55404

RE: Project Number Project Number S5242026

Dear Ms. Cole:

On July 5, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 17, 2016. 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 August 10, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on August 4, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 17, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 27, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 17, 2016, effective July 27, 2016 and therefore remedies outlined in our letter to you dated July 5, 2016, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under K67 at the time of the June 17, 2016 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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.

Sincerely,

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245242 Y1	A. Building B. Wing Y2	8/10/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0225	Correction	ID Prefix	F0226	Correction	ID Prefix	F0309	Correction
Reg. #	483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. #	483.13(c)	Completed	Reg. #	483.25	Completed
LSC		07/27/2016	LSC		07/27/2016	LSC		07/27/2016
ID Prefix	F0312	Correction	ID Prefix	F0315	Correction	ID Prefix	F0371	Correction
Reg. #	483.25(a)(3)	Completed	Reg. #	483.25(d)	Completed	Reg. #	483.35(i)	Completed
LSC		07/27/2016	LSC		07/27/2016	LSC		07/27/2016
ID Prefix	F0431	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	483.60(b), (d), (e)	Completed	Reg. #		Completed	Reg. #		Completed
LSC		07/27/2016	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GL/kfd	8/19/2016	33043	8/10/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/17/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245242	A. Building 01 - MAIN BUILDING 01 B. Wing	8/4/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0027	Correction Completed 07/27/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** TL/kfd	**DATE** 8/19/2016	**SIGNATURE OF SURVEYOR** 37009	**DATE** 8/4/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 6/23/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WP7I

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00164

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245242**
2.STATE VENDOR OR MEDICAID NO.
(L2) **159540700**

3. NAME AND ADDRESS OF FACILITY
(L3) **Augustana Health Care Center of Minneapolis**
(L4) **1007 EAST 14TH STREET**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/17/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **268** (L18)
13.Total Certified Beds **268** (L17)

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

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
~~X~~ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room
* Code: **B, 5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	268			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Lisa Hakanson, HFE NEII 07/15/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/05/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5242

On June 17, 2016 a recertification survey was completed at this facility. This survey found the most serious deficiencies in the facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), The facility has been given an opportunity to correct before remedies would be imposed. In addition at the time of the June 17, 2016 survey, investigaion of complaint numbers, H5242098, H5242099, H5242100, H542101, All complaints were found to be unsubstantiated. Refer to the CMS 2567 for both health and life safety coded along with the facility's plan of correction. Post Certification Revisit (PCR) to follow.

Further, the Documentation supporting the facility's request for a continuing waiver involving K0067 was forwarded to the CMS Region V Office for final detemination. Approval of the waiver request was recommended. Refer to the CMS 2786R Provision Number K84 Justification Page.

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 5, 2016

Ms. Jean Cole, Administrator
Augustana Health Care Center Of Minneapolis
1007 East 14th Street
Minneapolis, Minnesota 55404

RE: Project Number S5242026, H5242098, H5242099, H5242100 and H5242101

Dear Ms. Cole:

On June 17, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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. In addition, at the time of the June 17, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5242098, H5242099, H5242100 and H5242101 that were found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 27, 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 July 27, 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 September 17, 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 December 17, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

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

Sincerely,

Mark Meath

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. At the time of the recertification survey, complaint investigations were also conducted for H5242098, H5242099, H52432100 and H5242101. The complaints were unsubstantiated.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	F 225		7/27/16

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

Electronically Signed | 07/14/2016

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F 225	Continued From page 1 misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to report a missing wallet/money immediately to the administrator and designated State agency (SA), and to thoroughly investigate the allegation for 1 of 3 residents (R387) reviewed for abuse prohibition. Findings include: R387 reported in an interview on 6/14/16, at 9:51 a.m. $400 had been stolen from his wallet. He explained $100 of the $400 had been returned by a laundry employee, but $300 was still missing. R387 stated he "told everybody in the facility about it," including the director of nursing (DON), a registered nurse (RN)-A, a licensed social	F 225	Augustana Health Care Center of Minneapolis' plan of correction is a written credible assertion of substantial compliance with the Federal and State requirements of Nursing Facilities and/or skilled nursing facilities participating in the Federal Medicare or State Medical Assistance programs. Please note that nothing set forth in this document is to be or should be construed to be an admission by Augustana HCC of Minneapolis, or the validity or accuracy of any of the deficiencies cited by the Minnesota Dept. of Health relative to the survey, certification, and enforcement effort at issue. Further please note that	

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F 225	Continued From page 2 worker (LSW) and the security supervisor (SS). During a follow up interview with R387 on 6/17/16, at 9:54 a.m. the resident again stated that in March an unidentified nursing assistant (NA) was assisting him in the shower room. Following the shower he donned his robe, leaving his shorts and wallet and money on the floor, and immediately left the shower room. Upon realizing he had left his wallet, he returned tot he shower room and found the shorts and wallet were no longer there. The NA who had assisted him reported she had thrown the shorts in the laundry. R387 then told RN-A of the missing wallet containing money. RN-A went to the laundry room and "she was back in like 15 seconds." RN-A said she did not find the wallet and allegedly stated, "You know you are never going to get your money back." R387 said he did not appreciate how RN-A spoke to him, nor did he feel she carefully looked for the wallet or into the into the situation. He then went to the laundry room himself. R387 then said later that day he was in the smoking room when the "laundry guy" summoned him and they left the smoking room to talk. The laundry staff person then gave him $100 in $10 bills. However, R387 stated he was missing $400 in $20 bills, and still wanted the money back. R387 stated he reported RN-A's comment that he would not get his money back to other staff, and felt no one helped him look into the situation which was "just dropped." R387 also stated the security supervisor (SS) had told him that whomever took the wallet probably also had his money. He said the environmental director (ED) had also thrown away his birth certificate and state identification card while deep cleaning his room. R387 reported he asked wheat had happened to the missing papers and the ED said	F 225	any and all documents transmitted or otherwise provided by Augustana Health Care Center of Minneapolis in relation to the Plan of Correction, as well as any and all other communications in writing or otherwise by or on behalf of Augustana HCC of Minneapolis, at law and/or in equity, all of which are not waived and all of which are reserved and retained by, for and on behalf of Augustana HCC of Minneapolis. F225 It is the policy of Augustana Health Care Center to ensure that all alleged violations involving mistreatment, neglect, or abuse including injuries of unknown source and misappropriation of resident property are immediately reported to the administrator and other state officials in accordance with state law and to have evidence that all violations are thoroughly investigated. Corrective Action: Social Services Director met with identified resident R387 and again reviewed all findings of the investigation of his March 11, 2016 report of a missing wallet. Resident was asked if he currently had any cash or valuables he would like to have put in the safe or a resident trust account. The SS Director verified resident had a working locked drawer, and had the key on his person. SS Director also stressed the importance of immediately and accurately reporting any missing items to staff. Conversation was documented in the resident's medical record. 7-13-16	

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F 225	Continued From page 3 he threw the bag away thinking it was "just papers" and the bag was wet. R387 reported consistent information about missing $400 in $20 bills to a second surveyor on 6/15/16, when interviewed regarding a different matter. An admission Progress Note dated 1/11/16, noted R387 was alerted and oriented "and manages own affairs...explained facility is not liable for lost or stolen property and informed pt [patient] the facility has a safe pt can utilize...." A 4/4/16, Significant Change Minimum Data Set assessment revealed the resident's cognition was intact, and he displayed no behavioral problems or delirium symptoms. An Incident Report was attached and submitted to the SA on 3/11/16, indicating that on the previous day on 3/10/16, R387 reported his wallet with $400 missing to RN-A. Police were notified of the theft on 3/11/16, and a facility Issue/Concern form had been initiated. A Minneapolis Police Department report dated 3/11/16, at 11:47 a.m. revealed "Incident Details Offense 1: Theft" occurred on 3/10/16, between 1:00 and 5:00 p.m. in R387's room or the laundry room. The description of the incident showed the resident reported he went to the shower and left his shorts in the room unattended with his wallet in the pocket. Upon return, he noticed his shorts and were "'no where to be found'...Res. [resident] stated that later in the evening the laundry staff pulled him aside and stated they rechecked and found his shorts and returned five $10 dollar bills...The laundry room employee stated he found ten $100 [$10] bills ($100) in the pocket of	F 225	Identification of Other Residents: All current issue and concern forms and pending VA reports were reviewed to ensure immediately reporting to the administrator and state agency as required. 7-15-16 Measures Put in Place: Mandatory all staff education was completed to review Vulnerable Adult reporting, and investigating The policies on Vulnerable Adult Reporting and Investigation Procedure, and Missing Items were reviewed by all staff as a part of the above education. 7-26-17 Monitoring Mechanism: Per facility policy all VA reports are reviewed by the Administrator, DON, and QI Director for timely, accurate, and proper completion. Current Vulnerable Adult reports submitted, and pending are reviewed by the IDT team at the monthly QI / QAA meetings. VA trending patterns are reviewed at the quarterly QAA meetings for meeting an acceptable standard of practice as required for VA investigating and reporting. 7-27-17 Responsible Person/s Administrator Director of Nursing Director of Quality Improvement	

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the resident's shorts and that is what he returned to the resident. Security is obtaining statements from all involved."

A 3/11/16, Issue and Concern Form revealed, "Resident reported [on 3/10/16] he left his wallet in his shorts and it got sent down to laundry. This writer went to the laundry to search for it but was unable to find...Part II: Document investigation/actions taken: Security spoke to several staff. [R387's] story changed among all employees involved. Laundry staff [name] checked again and did find $100 in (tens) which he returned to [R387] on 3/10/16. Statements are included, however, due to conflicting statements to staff it is not possible to verify possession or loss of the monies." The report did not indicate whether the administrator was immediately notified of the missing wallet and the signature and date portion was left blank. Part III indicated a vulnerable adult (VA) report was filed with the SA on 3/11/16, the day after the resident reported his wallet was missing.

The SS Incident Report (not dated) noted that the write had been approached on 3/11/16, at approximately 7:30 a.m. by R387 who reported missing his wallet and money. He reportedly went to the shower and left his shorts containing his wallet on the floor in the shower room. The wallet contained $400 in $20 bills, a buss pass and Medicare card. He reportedly told RN-A..."Later in the evening the man from laundry came to the smoke room, had him commode out and then the laundry employee gave [R387] five $10 bills. {R387] thinks there is some conspiracy and theft. He had all twenties ($400) in his wallet and [RN-A] stated that the laundry did not have his wallet, now laundry is giving him $50. I advised

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[R387] I would check into the matter. I checked the evening security report and id not find any report of theft not a I/C [Incident Concern] form created. I checked some video and found that a male laundry employee did on [sic] fact call [R387] out of the smoke room at 5:55 pm and spoke to him for a short amount of time and the door of the smoke room, then wheeled [R387] out of camera range toward the freight elevator. At 6:58 pm the laundry employee returned [R387] to the smoke room. The only thing visible in [R387's] hands were his pack of cigarettes...." The report also indicated the laundry employee reported "he and the day shift female" found ten $10 bills in the shorts pocket and he gave the residnets the money.

A laundry staff (LS)-B wrote a statement on 3/11/16, indicating "Two laundry employees LS-A and LS-B went through the soiled linen and found the short [sic] with no wallet in the pocket. The resident was present. Later that day the employee [LS-B] found some money while he was taken [sic] out linen from the dryer it was $100 dollar [sic] in 10 dollar bill [sic] and he went to the smoking room and gave the 100 dollars to the resident and the resident said that he is still missing 300 dollars." Although LS-B indicates LS-A was present when the shorts were found without money in the pocket, no statement was taken from LS-A to confirm her part as described in LS-B's statement, or what she knew of the situation.

Although documentation and interviews revealed all persons named in the investigative report were told consistent stories by R387, the investigative report dated 3/10/16, noted the resident's "statement to security is so different than what he

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stated to nurse, case manager, social services and Director of Environmental Services. The resident confirmed he thinks his wallet with the money went to laundry inside his soiled shorts [consistently reported by the resident even several months later]. [LS-B and LS-A] from laundry double checked the laundry and found $100 loose cash in resident's shorts pockets after they had been laundered [inconsistent with LS-B's report that he and LS-A checked the shorts and found no money, but later LS-B found $100 in lose $10 bills in the dryer]. The money was returned to the resident. Resident did express concern he that he had only twenty dollar bills in the wallet and has five ($50) [documentation varies whether $50 or $100] returned to him. The laundry staff confirmed they returned ten $10 bills to resident. However, no wallet has been located...Statements have been received by all staff and display the inconsistent statements of the resident. No futher action will be taken at this time. If further information is obtained, MPD [Minneapolis Police Department] and MDH will be updated."

On 6/17/16, at 10:22 a.m. the SSD verified she had assisted R387 to send a signed letter to the Pentagon in order to replace his birth certificate, but the process would take two to three months. The facility had paid the required $50 fee and the SSD showed the surveyor a copy of a $50 check and a letter dated 4/15/16. The SSD stated resident was forgetful, was taking a lot of medications and could be a little "foggy." The SSD stated the resident came to her office frequently. Her part was to help the resident get his birth certificate and state ID replaced, but she had nothing to do with R387's missing money (although later said she had assisted the resident

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to search his room). The SSD stated the resident was known to carry a lot of money in his wallet, and signed an agreement in 1/16, at the time of his admission that the facility was not responsible for lost or stolen money. The SSD stated if theft was suspected, an issue concern form was filled out and the staff followed the abuse procedure. If over $25 the SS immediately filed a VA report. The facility typically did not replace money, but it depended on how the money was lost and she did not know who was at fault in this situation with R387's missing wallet. The SSD stated the SS resolved incidents of theft of money, and the laundry staff had found five $10 bills in the dryer. When asked how or whom returned the resident's wallet, the SSD said she did not know, but would check the report and let the surveyor know. However, no further documentation was brought to the surveyor specifying who had returned the $50 or $100 to the resident.

At 10:17 a.m. the clinical manager stated she was unaware R387 had been missing his wallet or any money. She was aware the resident had been missing his birth certificate and state identification card. Replacements had been ordered, however, this was proving difficult, as the resident was not born out of the country. She believed the social services director (SSD) was helping resident.

At 11:32 a.m. RN-A explained that very close to the end of her shift at about 2:15 p.m. R387 reported he was missing his wallet and the NA said it went to the laundry. R387 had reported the wallet contained money and she did not ask the contents, but after the shower his shorts and wallet had been sent to the laundry. RN-A stated she told R387 "let me run down to the laundry room" and there she talked to a female laundry

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staff who said "'nothing showed up.'" RN-A said she then told R387 she would check with laundry staff the next day, as it could have been in the process of being laundered. The next day R387 reported his wallet had been returned, but not the same money he had in his wallet, which was about $400. RN-A then notified the SSD, initiated a Concern Form, and informed the SS.

At 11:40 a.m. the ED stated after a room search by the SS and SSD, he went down to laundry and talked to a laundry staff (LS)-A who had not found anything. The ED instructed the laundry staff to look for the wallet and missing money. The following morning LS-B said in fact LS-B had found 10 $10 bills in laundry, which LS-B returned to R387. The ED stated he confirmed the resident actually had $20 bills in his wallet the previous day because he had seen them. He cleaned the residents' room and found loose $1's and $5's and asked the resident if he wanted them put in his wallet. When he placed the money in the wallet, he saw the wallet contained $20 bills. However, the ED stated laundry staff reportedly found $100 in $10 bills, and had written a statement to that effect.

On 6/17/16, at 11:55 a.m. RN-A stated she wrote the issue Concern Form because R387's money was missing. RN-A stated she probably should have completed the form the day the wallet was reported missing, but waited as she thought it was being laundered, and normally "99.5%" of missing items were found. She planned to return to the laundry the following day. RN-A reported she also thought she had 24 hours to report allegations to the SA, and only had to immediately report when harm had occurred.

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At 12:05 p.m. the SS stated he reviewed videotape recordings when LS-B reported returning money to R387, however, LS-B "went off camera" when the money was given to R387. The SS stated because of the inconsistency of stories R387 reportedly told,and re-interviewing of people, the issue sat idle and had come to a difficult situation to decide what had happened. The SS stated that instead of returning the money to the resident, LS-B should have instead returned it to management staff, particularly because the bills returned to the resident did not matched the description of what the resident reported he was missing.

The ED stated at 12:10 p.m. he had instructed the laundry staff to turn money found in laundry to the supervisor. The ED stated the next morning after hearing the laundry staff had given found money and gave it directly to R387, he instructed each of the laundry staff that going forward, all money found was to be brought to the security or laundry supervisor and then kept in a locked office.

At 12:15 p.m. SS stated he talked with R387, but was "kind of at a dead end" and could not get any further, as he did not have any proof without cameras and resident's missing money was not something that was replaced at the facilty.

At 12:17 p.m. The SSD stated that under certain circumstances the facility might replace a resident's missing/stolen money.

At approximately 1:00 p.m. RN-A provided a written statement dated that day. RN-A's statement read, "On the day that [R387] reported to me that his wallet was sent to laundry there

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was absolute no mention to me of any money missing. I went to the laundry because at this point the wallet technically was not missing because the resident stated it went to laundry...reported to resident that laundry staff did not see the wallet and that I would follow up with them early the next morning because in the past, items that were sent to laundry would usually appear the next day. I came in early the next day specifically to go to laundry to look for resident's wallet and was informed by resident that he had found his wallet. I said to resident 'Good, issue has been resolved' and went on with my day. Shortly afterwards (about fifteen or twenty minutes) [R387] came to me and said 'you know, I had four hundred dollars in twenty dollar bills and they returned to me some 10's.' At that point [the day after the resident reported the missing wallet/money] I called social services and immediately completed an issue and concern form and started the investigative process."

The director of nursing (DON) stated at 1:30 p.m. any allegation of mistreatment was to be immediately reported to the nurse, who then immediately reported it to their supervisor, clinical manager, shift manager, the DON, and administrator and the SA. The DON stated she and the administrator were on call 24-hours a day. Although she had no involvement in the missing wallet/money, she was aware of the situation. The DON stated the facility did not replace residents' lost/stolen items.

At 1:50 p.m. the administrator stated she was notified immediately of any allegations of abuse and always talked with the DON about each situation. The administrator stated she was notified of R387's missing wallet and money, but

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did not know the time, but it would have been noted on the security report. The administrator stated she was familiar with R387's report of missing money. The administrator stated if the facility felt reasonably negligent, the same value would be reimbursed to a resident, however, there had been no evidence in this situation on the part of the facility.

A 9/12, Lost Items policy indicated"Staff will be trained to care for resident belongings carefully. If an item is lost, a report will be completed...If management feels that staff omitted a necessary step in keeping resident belongings safe, the administrator may consider reimbursing...Missing items valued at greater than $50 will be reported to CEP [Common Entry Point--designated SA]...If a resident belonging is lost, an attempt to try to find the item will be made. A report will be completed and given to the staff person most appropriate to investigate missing item ...Call into CEP will occur as indicated by investigation. In some cases, if there has been an accident with a resident's belongings, an Administrator or Director of Housing may choose to reimburse or pay for glasses, dentures, etc. expenses up to $1000 should be paid for out of operating funds."

A 2/15, Vulnerable Adult Reporting and Investigation Procedure indicated "Misappropriation of resident property and Theft. C. Upon receiving the report the DON (or designee) will 1. Determine if an employee(s) allegedly perpetrated the incident. 2. If the employee(s) are potentially or suspected to be involved, the employee(s) is informed that s/he is suspended pending investigation. D. The Administrator (or Corporate Designee if the Administrator is on PTO) and Director of Nursing

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F 225	Continued From page 12 (or designee) will be informed immediately of maltreatment/abuse or neglect potential and will appoint a staff person to investigate the alleged incident ...J. All incidents must be reported to MDH [Minnesota Department of Health] via a secure website. This is a two-step process 1. Immediate initial reporting the incident 2. Submitting a final investigative report within 5 working days. The Administrator will be informed of the conclusions of the investigative process."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to operationalize policies that prohibited misappropriation of property related to potential theft for 1 of 3 residents (R387) reviewed for abuse prohibition. Findings include: A 2/15, Vulnerable Adult Reporting and Investigation Procedure indicated "Misappropriation of resident property and Theft. C. Upon receiving the report the DON (or designee) will 1. Determine if an employee(s) allegedly perpetrated the incident. 2. If the employee(s) are potentially or suspected to be involved, the employee(s) is informed that s/he is	F 226	F226: It is the policy of the Augustana Health Care Center to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Corrective Action: Social Services Director met with identified resident R387 and again reviewed all findings of the investigation of his March 11 2016 report of a missing wallet. Resident was asked if he currently had any cash or valuables he would like to have put in a resident trust account, or locked in the facility safe. SS Director	7/27/16

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F 226	Continued From page 13 suspended pending investigation. D. The Administrator (or Corporate Designee if the Administrator is on PTO) and Director of Nursing (or designee) will be informed immediately of maltreatment/abuse or neglect potential and will appoint a staff person to investigate the alleged incident ...J. All incidents must be reported to MDH [Minnesota Department of Health] via a secure website. This is a two-step process 1. Immediate initial reporting the incident 2. Submitting a final investigative report within 5 working days. The Administrator will be informed of the conclusions of the investigative process." R387 reported in an interview on 6/14/16, at 9:51 a.m. $400 had been stolen from his wallet. He explained $100 of the $400 had been returned by a laundry employee, but $300 was still missing. R387 stated he "told everybody in the facility about it," including the director of nursing (DON), a registered nurse (RN)-A, a licensed social worker (LSW) and the security supervisor (SS). During a follow up interview with R387 on 6/17/16, at 9:54 a.m. the resident again stated that in March an unidentified nursing assistant (NA) was assisting him in the shower room. Following the shower he donned his robe, leaving his shorts and wallet and money on the floor, and immediately left the shower room. Upon realizing he had left his wallet, he returned tot he shower room and found the shorts and wallet were no longer there. The NA who had assisted him reported she had thrown the shorts in the laundry. R387 then told RN-A of the missing wallet containing money. RN-A went to the laundry room and "she was back in like 15 seconds." RN-A said she did not find the wallet and allegedly stated, "You know you are never going to get your	F 226	verified resident had a working locked drawer, and had the key on his person. SS Director also stressed the importance or immediately and accurately reporting any missing items to staff. Conversation was documented in the resident medical record. 7-13-16 Policy #109 Missing Items was updated to emphasize immediate reporting of missing items, the importance of accuracy when reporting missing items, and the requirement to report to the state agency as a VA as indicated by facility policy 7-10-16 Identification of Other Residents: All current issue and concern forms and pending VA reports were reviewed to ensure immediately reporting to the administrator and state agency as required. 7-15-16 Measures Put in Place: Mandatory all staff education was completed to review Vulnerable Adult reporting, and investigating The policies on Vulnerable Adult Reporting and Investigation Procedure, and Missing Items were reviewed by all staff as a part of the above education. 7-26-16 Monitoring Mechanism: Per facility policy all VA reports are reviewed by the Administrator, DON, and QI Director for timely, accurate, and proper completion. Current Vulnerable Adult reports submitted and pending are reviewed by the IDT team at the monthly QI / QAA meetings. VA trending patterns	

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F 226	Continued From page 14 money back." R387 said he did not appreciate how RN-A spoke to him, nor did he feel she carefully looked for the wallet or into the into the situation. He then went to the laundry room himself. R387 then said later that day he was in the smoking room when the "laundry guy" summoned him and they left the smoking room to talk. The laundry staff person then gave him $100 in $10 bills. However, R387 stated he was missing $400 in $20 bills, and still wanted the money back. R387 stated he reported RN-A's comment that he would not get his money back to other staff, and felt no one helped him look into the situation which was "just dropped." R387 also stated the security supervisor (SS) had told him that whomever took the wallet probably also had his money. He said the environmental director (ED) had also thrown away his birth certificate and state identification card while deep cleaning his room. R387 reported he asked wheat had happened to the missing papers and the ED said he threw the bag away thinking it was "just papers" and the bag was wet. R387 reported consistent information about missing $400 in $20 bills to a second surveyor on 6/15/16, when interviewed regarding a different matter. An admission Progress Note dated 1/11/16, noted R387 was alerted and oriented "and manages own affairs...explained facility is not liable for lost or stolen property and informed pt [patient] the facility has a safe pt can utilize...." A 4/4/16, Significant Change Minimum Data Set assessment revealed the resident's cognition was intact, and he displayed no behavioral problems or delirium symptoms.	F 226	are reviewed at the quarterly QAA meetings for meeting an acceptable standard of practice as required for VA investigating and reporting. 7-27-16 Responsible Person/s Administrator Dir. of Nursing Dir. of Quality Improvement	

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An Incident Report was attached and submitted to the SA on 3/11/16, indicating that on the previous day on 3/10/16, R387 reported his wallet with $400 missing to RN-A. Police were notified of the theft on 3/11/16, and a facility Issue/Concern form had been initiated.

A Minneapolis Police Department report dated 3/11/16, at 11:47 a.m. revealed "Incident Details Offense 1: Theft" occurred on 3/10/16, between 1:00 and 5:00 p.m. in R387's room or the laundry room. The description of the incident showed the resident reported he went to the shower and left his shorts in the room unattended with his wallet in the pocket. Upon return, he noticed his shorts and were "'no where to be found'...Res. [resident] stated that later in the evening the laundry staff pulled him aside and stated they rechecked and found his shorts and returned five $10 dollar bills...The laundry room employee stated he found ten $100 [$10] bills ($100) in the pocket of the resident's shorts and that is what he returned to the resident. Security is obtaining statements from all involved."

A 3/11/16, Issue and Concern Form revealed, "Resident reported [on 3/10/16] he left his wallet in his shorts and it got sent down to laundry. This writer went to the laundry to search for it but was unable to find...Part II: Document investigation/actions taken: Security spoke to several staff. [R387's] story changed among all employees involved. Laundry staff [name] checked again and did find $100 in (tens) which he returned to [R387] on 3/10/16. Statements are included, however, due to conflicting statements to staff it is not possible to verify possession or loss of the monies." The report did not indicate whether the administrator was immediately

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notified of the missing wallet and the signature and date portion was left blank. Part III indicated a vulnerable adult (VA) report was filed with the SA on 3/11/16, the day after the resident reported his wallet was missing.

The SS Incident Report (not dated) noted that the write had been approached on 3/11/16, at approximately 7:30 a.m. by R387 who reported missing his wallet and money. He reportedly went to the shower and left his shorts containing his wallet on the floor in the shower room. The wallet contained $400 in $20 bills, a buss pass and Medicare card. He reportedly told RN-A..."Later in the evening the man from laundry came to the smoke room, had him commode out and then the laundry employee gave [R387] five $10 bills. {R387] thinks there is some conspiracy and theft. He had all twenties ($400) in his wallet and [RN-A] stated that the laundry did not have his wallet, now laundry is giving him $50. I advised [R387] I would check into the matter. I checked the evening security report and id not find any report of theft not a I/C [Incident Concern] form created. I checked some video and found that a male laundry employee did on [sic] fact call [R387] out of the smoke room at 5:55 pm and spoke to him for a short amount of time and the door of the smoke room, then wheeled [R387] out of camera range toward the freight elevator. At 6:58 pm the laundry employee returned [R387] to the smoke room. The only thing visible in [R387's] hands were his pack of cigarettes...." The report also indicated the laundry employee reported "he and the day shift female" found ten $10 bills in the shorts pocket and he gave the residnets the money.

A laundry staff (LS)-B wrote a statement on

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F 226	Continued From page 17 3/11/16, indicating "Two laundry employees LS-A and LS-B went through the soiled linen and found the short [sic] with no wallet in the pocket. The resident was present. Later that day the employee [LS-B] found some money while he was taken [sic] out linen from the dryer it was $100 dollar [sic] in 10 dollar bill [sic] and he went to the smoking room and gave the 100 dollars to the resident and the resident said that he is still missing 300 dollars." Although LS-B indicates LS-A was present when the shorts were found without money in the pocket, no statement was taken from LS-A to confirm her part as described in LS-B's statement, or what she knew of the situation. Although documentation and interviews revealed all persons named in the investigative report were told consistent stories by R387, the investigative report dated 3/10/16, noted the resident's "statement to security is so different than what he stated to nurse, case manager, social services and Director of Environmental Services. The resident confirmed he thinks his wallet with the money went to laundry inside his soiled shorts [consistently reported by the resident even several months later]. [LS-B and LS-A] from laundry double checked the laundry and found $100 loose cash in resident's shorts pockets after they had been laundered [inconsistent with LS-B's report that he and LS-A checked the shorts and found no money, but later LS-B found $100 in lose $10 bills in the dryer]. The money was returned to the resident. Resident did express concern he that he had only twenty dollar bills in the wallet and has five ($50) [documentation varies whether $50 or $100] returned to him. The laundry staff confirmed they returned ten $10 bills to resident. However, no wallet has been	F 226		

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located...Statements have been received by all staff and display the inconsistent statements of the resident. No futher action will be taken at this time. If further information is obtained, MPD [Minneapolis Police Department] and MDH will be updated."

On 6/17/16, at 10:22 a.m. the SSD verified she had assisted R387 to send a signed letter to the Pentagon in order to replace his birth certificate, but the process would take two to three months. The facility had paid the required $50 fee and the SSD showed the surveyor a copy of a $50 check and a letter dated 4/15/16. The SSD stated resident was forgetful, was taking a lot of medications and could be a little "foggy." The SSD stated the resident came to her office frequently. Her part was to help the resident get his birth certificate and state ID replaced, but she had nothing to do with R387's missing money (although later said she had assisted the resident to search his room). The SSD stated the resident was known to carry a lot of money in his wallet, and signed an agreement in 1/16, at the time of his admission that the facility was not responsible for lost or stolen money. The SSD stated if theft was suspected, an issue concern form was filled out and the staff followed the abuse procedure. If over $25 the SS immediately filed a VA report. The facility typically did not replace money, but it depended on how the money was lost and she did not know who was at fault in this situation with R387's missing wallet. The SSD stated the SS resolved incidents of theft of money, and the laundry staff had found five $10 bills in the dryer. When asked how or whom returned the resident's wallet, the SSD said she did not know, but would check the report and let the surveyor know. However, no further documentation was brought

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to the surveyor specifying who had returned the $50 or $100 to the resident.

At 10:17 a.m. the clinical manager stated she was unaware R387 had been missing his wallet or any money. She was aware the resident had been missing his birth certificate and state identification card. Replacements had been ordered, however, this was proving difficult, as the resident was not born out of the country. She believed the social services director (SSD) was helping resident.

At 11:32 a.m. RN-A explained that very close to the end of her shift at about 2:15 p.m. R387 reported he was missing his wallet and the NA said it went to the laundry. R387 had reported the wallet contained money and she did not ask the contents, but after the shower his shorts and wallet had been sent to the laundry. RN-A stated she told R387 "let me run down to the laundry room" and there she talked to a female laundry staff who said "'nothing showed up.'" RN-A said she then told R387 she would check with laundry staff the next day, as it could have been in the process of being laundered. The next day R387 reported his wallet had been returned, but not the same money he had in his wallet, which was about $400. RN-A then notified the SSD, initiated a Concern Form, and informed the SS.

At 11:40 a.m. the ED stated after a room search by the SS and SSD, he went down to laundry and talked to a laundry staff (LS)-A who had not found anything. The ED instructed the laundry staff to look for the wallet and missing money. The following morning LS-B said in fact LS-B had found 10 $10 bills in laundry, which LS-B returned to R387. The ED stated he confirmed the resident actually had $20 bills in his wallet the previous

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day because he had seen them. He cleaned the residents' room and found loose $1's and $5's and asked the resident if he wanted them put in his wallet. When he placed the money in the wallet, he saw the wallet contained $20 bills. However, the ED stated laundry staff reportedly found $100 in $10 bills, and had written a statement to that effect.

On 6/17/16, at 11:55 a.m. RN-A stated she wrote the issue Concern Form because R387's money was missing. RN-A stated she probably should have completed the form the day the wallet was reported missing, but waited as she thought it was being laundered, and normally "99.5%" of missing items were found. She planned to return to the laundry the following day. RN-A reported she also thought she had 24 hours to report allegations to the SA, and only had to immediately report when harm had occurred.

At 12:05 p.m. the SS stated he reviewed videotape recordings when LS-B reported returning money to R387, however, LS-B "went off camera" when the money was given to R387. The SS stated because of the inconsistency of stories R387 reportedly told,and re-interviewing of people, the issue sat idle and had come to a difficult situation to decide what had happened. The SS stated that instead of returning the money to the resident, LS-B should have instead returned it to management staff, particularly because the bills returned to the resident did not matched the description of what the resident reported he was missing.

The ED stated at 12:10 p.m. he had instructed the laundry staff to turn money found in laundry to the supervisor. The ED stated the next morning

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after hearing the laundry staff had given found money and gave it directly to R387, he instructed each of the laundry staff that going forward, all money found was to be brought to the security or laundry supervisor and then kept in a locked office.

At 12:15 p.m. SS stated he talked with R387, but was "kind of at a dead end" and could not get any further, as he did not have any proof without cameras and resident's missing money was not something that was replaced at the facilty.

At 12:17 p.m. The SSD stated that under certain circumstances the facility might replace a resident's missing/stolen money.

At approximately 1:00 p.m. RN-A provided a written statement dated that day. RN-A's statement read, "On the day that [R387] reported to me that his wallet was sent to laundry there was absolute no mention to me of any money missing. I went to the laundry because at this point the wallet technically was not missing because the resident stated it went to laundry...reported to resident that laundry staff did not see the wallet and that I would follow up with them early the next morning because in the past, items that were sent to laundry would usually appear the next day. I came in early the next day specifically to go to laundry to look for resident's wallet and was informed by resident that he had found his wallet. I said to resident 'Good, issue has been resolved' and went on with my day. Shortly afterwards (about fifteen or twenty minutes) [R387] came to me and said 'you know, I had four hundred dollars in twenty dollar bills and they returned to me some 10's.' At that point [the day after the resident reported the missing

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F 226	Continued From page 22 wallet/money] I called social services and immediately completed an issue and concern form and started the investigative process." The director of nursing (DON) stated at 1:30 p.m. any allegation of mistreatment was to be immediately reported to the nurse, who then immediately reported it to their supervisor, clinical manager, shift manager, the DON, and administrator and the SA. The DON stated she and the administrator were on call 24-hours a day. Although she had no involvement in the missing wallet/money, she was aware of the situation. The DON stated the facility did not replace residents' lost/stolen items. At 1:50 p.m. the administrator stated she was notified immediately of any allegations of abuse and always talked with the DON about each situation. The administrator stated she was notified of R387's missing wallet and money, but did not know the time, but it would have been noted on the security report. The administrator stated she was familiar with R387's report of missing money. The administrator stated if the facility felt reasonably negligent, the same value would be reimbursed to a resident, however, there had been no evidence in this situation on the part of the facility.	F 226		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		7/27/16

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify and monitor bruising for 1 of 1 resident (R342) reviewed for non-pressure related skin conditions. Findings include: R342 stated on 6/14/16, at 3:03 p.m. she did not know how she sustained observable bruises on her arms, although she recalled hitting her arm on the bathroom door after her shower. At 3:44 p.m. a registered nurse (RN)-D was asked if she was aware of the bruises on R342's arms. RN-D was unaware, but would talk to other staff about it. The surveyor informed RN-D R342 had reported a nursing assistant (NA)-B suggested about a week prior she should have the bruises checked by a nurse. On 6/15/16, at 1:45 p.m. R342 was lying in bed, light green bruises noted on her legs, as well as an abrasion on her knee. R342 stated the abrasion occurred from her bath. Following the observation, a trained medication assistant (TMA)-B then reported she was unaware of any skin issues for R342. R342's quarterly Minimum Data Set dated 6/7/16, indicated R342 had moderately impaired cognition. An Incident Review Form dated 6/14/16, indicated R342 had a minor injury on left wrist	F 309	F309 It is the policy of the Augustana Health Care Center to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Corrective Action: During he survey an extensive interview was completed with identified resident R342 re: origin of bruises. A VA report was filed per policy for the bruises of unknown origin. A complete body visual and skin check was also completed on 6-16-16 Identification of Other Residents: A facility wide skin audit of all LTC residents will be implemented to identify all current bruises. Bruises noted on the audit will be reviewed by the clinical managers to ensure all were documented on and/or reported per facility policy. 7-26-16 Measures Put in Pace: Mandatory education for all nursing staff on Augustana Skin Protocol, including all components of a visual body audit and immediately reporting skin changes to the charge nurse. 7-26-16 Monitoring Mechanism: 15% random audits will be conducted on all LTC units for the next 90 days to	

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	245242	A. BUILDING _____ B. WING _____	06/17/2016

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F 309	Continued From page 24 dime sized, right forearm quarter sized, left shin quarter size and faded yellow, R342 was receiving anticoagulant medication and bruised easily. Interventions included protective Geri Sleeves and Derma Savers to both legs. The form indicated R342 had bruises on right and left arms, two quarter size reddish-blue bruises. The resident did not know how the bruising occurred. Staff was to monitor and document bruises to left wrist, right wrist. On 6/16/16, at 9:22 a.m. NA-C stated R342 had fragile skin, but had not noticed any bruising. If so, he would have notified the supervisor right away. NA-C said the nurses performed skin checks when the NAs finished drying the residents following their baths. At 9:24 a.m. at 9:24 a.m. NA-B stated at times he had helped R342 with cares and had noticed the bruises on R342's hands two days ago. NA-B said he did not inform the supervisor, as he was only assisting with cares and was not primarily responsible for the resident that day. NA-B said he had asked the resident how she sustained the bruises and she stated she did not know. NA-B explained R342 moved around in bed a lot and may have bumped her hand on the wall. NA-B stated any time a NA saw anything different with a resident or a bruise they were instructed to inform the charge nurse. NA-B said when he worked with the resident two weeks prior he did not notice any busies. NA-B said nurses performed weekly skin audits following a resident's bath. At 9:47 a.m. NA-D stated he had worked with R342 on 6/13/16, and had not noticed any bruises and that none of the nurses had mentioned any bruises on R342.	F 309	ensure clinical competency in Augustana skin protocol. 7-26-16 8-26-16 9-26-16 Audits will be reviewed by the Quality Improvement Committee for compliance with Augustana Skin protocol and maintaining clinical competency in skin care. 7-27-16 8-31-16 9-30-16 Responsible Person/s Dir. of Staff Development Clinical Managers Dir. Of Quality Improvement	

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F 309	Continued From page 25 On 6/16/16, at 9:58 a.m. TMA-B stated nurses completed skin checks after every resident bath or if something was reported. At 9:59 a.m. a licensed practical nurse (LPN)-D stated nurses completed resident skin checks after every bath and when something was reported, and then documented anything abnormal or not seen before on the resident. LPN-D stated she had worked on 6/14/16, but was unaware nor had been informed of any bruising on R342. LPN-D stated when she saw a bruise on a resident she notified the nurse manager, investigated how it might have happened, and then provided an update to the family "and everybody." LPN-D stated when a resident had a bruise it would be put on the 24-hour communication board, and if needed a treatment would be put on the electronic medication administration/treatment record (EMAR/ETAR) and then monitored for healing. LPN-D stated when she documented on bruises she would document the color, size and location of the bruise and would ask resident about pain with the bruising. LPN-D verified there was no identification of bruises on R342's 6/7/16 bath check, nor were bruises monitored on the EMAR/ETAR. On 6/16/16, at 10:19 a.m. TMA-B stated she had seen R342's bruises on R342 "today" At 10:20 a.m. RN-E stated NAs were to report any unusual skin conditions and bruises observed on residents. At 10:28 a.m. RN-F stated NAs reported any resident skin condition and nurses checked	F 309		

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F 309	Continued From page 26	F 309		

residents' skin every week. RN-F stated bruises would be monitored for size and change in size or color and bruises would fade in color. RN-F verified an event had been opened on 6/14/16 at 4:25 p.m. regarding R342's bruises and would now be monitored. RN-F said the monitoring was unclear, but the nurse would clarify the size, location, and color of the bruises that were being monitored with RN-D who had stated the monitoring.

At 10:46 a.m. RN-D stated she expected the nurses to continue to document on bruises once identified, including the appearance, measurements, color and if swollen. Complete body audits were to be completed during weekly skin checks.

On 6/16/16, at 10:55 a.m. R342 was again observed lying in bed and three greenish bruises on left shin, a small circular greenish bruise on left outer ankle, a small greenish bruise on left outside arm, bruise on hand, bruises on lower right forearm, and an abrasion under her right knee were noted.

R342's care plan indicated R342 was on aspirin therapy for atrial fibrillation and was at risk for bruising due to anticoagulant use. Interventions included the use of Geri-Sleeves at all times.

During an interview with the director of nursing (DON) on 6/17/16, at 1:22 p.m. she stated NAs were expected to monitor residents' skin every shift and report to nurse any changes and nurses were expected to inspect the bruise, start an event, see what caused it, determine the cause, and if bigger than a quarter and unknown origin and cannot determine the cause submit a

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F 309	Continued From page 27 vulnerable adult (VA) report. Documentation should have included descriptors, new/old, healing, size, color, quarter, dime size, etc. The documentation should have noted decreasing size and some type of measurements. The DON stated green in color usually meant healing, dark color usually meant a new bruise. R342's bruises should have been monitored according to the DON, as the resident had anticoagulant treatment (known to contribute to brusing) and in the past they had filed a VA report related to R342's bruising. When asked about the documentation found on R342's bruising DON stated she would have expected better skin monitoring and better description of the bruises No skin care policy was provided by the facility.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide activities of daily living (ADLs) when a resident was unable to perform those cares for 1 of 1 resident (R170) reviewed for activities of daily living. Findings include: R170 was observed on 6/14/16, at 11:33 a.m.	F 312	F312: It is the policy of Augustana Health Care Center to provide the necessary services to maintain good nutrition, grooming, personal, and oral hygiene. Corrective Action: Resident was offered and accepted nail care day 6-17-16 of the survey, staff to maintain nail care with weekly bath and at	7/27/16

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F 312	Continued From page 28 The resident had long, dirty fingernails, and the middle fingernail on the left hand was jagged and chipped. Several nails were growing over the tops of the fingers. R170 was again observed on 6/16/16, at 9:24 a.m. His nails remained long, dirty and chipped. When asked about his nails, R170 reported they were "too long" and explained he should have been receiving nail care each Saturday with his weekly bath. The resident stated, "They [staff] ask me if I want my nails cut, but then they don't come back." The Nursing Assistant (NA) care sheet identified Saturday a.m. as R170's bath day and directed staff to assist with grooming and nail care. The current care plan edited 4/6/16 noted R170 required extensive assistance to complete grooming tasks related to his diagnoses, paralysis on one side of the body, and memory loss. During an interview on 6/16/16, at 9:27 a.m. a licensed practical nurse (LPN)-A stated, "Usually nurses will do nails as needed" explaining further that nail care was not routinely completed on a resident's scheduled bath day. She further explained that nail care was initiated by staffs' observation, and the facility did not have a system to ensure nail care was being addressed consistently. At 9:40 a.m. a registered nurse (RN)-A then entered R170's room. She confirmed the resident's fingernails were chipped and dirty. RN-A said she would have expected nail care to have been completed on the resident's last bath day, however did not feel the resident's nails were too long, as that was his preference. RN-A verified the nails on his left, contracted hand	F 312	additional times if needed. Identification of Other Residents: A facility wide audit of all LTC residents was conducted to ensure all needed nail care was implemented. 7-15-16 Measures Put in Place: Mandatory education for all nursing staff on the importance of nail care, and procedure for ensuring nail care is done weekly with bath and PRN as needed. 7-26-16 Monitoring Mechanism: 15% random audits of nail care will be conducted on all units for the next 90 days to ensure nail care is offered and implemented weekly and PRN as needed. 7-26-16 8-26-16 9-26-16 Audits will be reviewed by the Quality Improvement committee for compliance with providing nail care services for residents. 7-27-16 8-31-16 9-30-16 Responsible Person/s Dir. of Staff Development Clinical Managers Dir. of Quality Improvement	

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F 312	Continued From page 29 could have potentially altered the resident's skin due to "clenching" of the hand. RN-A confirmed evidence of nail care was lacking in the documentation, and it was expected nail care would be addressed at least weekly for all residents. On 6/17/16, at 12:57 p.m. the assistant director of nursing (ADON) stated via telephone conversation that when the facility incorporated the electronic Matrix system for resident care and records, it did not include a section to address nail care or body audits. Although the facility added skin audits into the system, nail care was not added. She further stated that nail care was a standard of care and it was expected the task would have been completed weekly and as needed for each resident. If a resident declined nail care, a note of explanation would be made in the resident's record. A review of R170's records lacked any indication of nail care completion or note indicating the resident declined nail care. The facility's 9/14, Policy for Nail Care indicated, "All residents will receive proper and medically indicated nail care as required to maintain a clean, neat appearance of the nails, to support a patient's self-esteem and morale; to prevent problems caused by dry skin, broken fingernails, long nails or hang nails." Nurses were directed to complete weekly inspections of a resident's nails on bath day, and determine the NA responsibility for nail care for all residents.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		7/27/16

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F 315	Continued From page 30 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess urinary incontinence in order to formulate a plan to minimize the risk for incontinence for 1 of 1 resident (R290) reviewed for urinary incontinence. Findings include: R290 was emerging from the bathroom when the surveyor knocked on her door on 6/16/16, at approximately at 7:45 a.m. R290 was then interviewed, and informed the surveyor she was able to use the toilet without assistance from staff. She was unsure whether she wore underwear or an incontinent brief. During the interview R290 was very distracted and needed redirection to return to the topic being discussed. R290's admission Minimum Data Set (MDS) dated 1/28/16, indicated the resident was continent of urine. However, a quarterly MDS 90 days later dated 4/19/16, indicated the resident was incontinent of urine, was not on a toileting program, and required staff's assistance to use	F 315	F315: It is the policy of the Augustana Health Care Center of Minneapolis to comprehensively assess urinary continence in order to formulate a plan to minimize the risk for incontinence. Corrective Action: A comprehensive bowel and bladder assessment was implemented and completed on 6-21-16 for identified resident R290. Care plan was updated reflecting change in continence status and care interventions. Identification of Other Residents: All MDS's for the past 180 days were audited for any change in continence status. Any residents with a change in continence were assessed per facility policy for bowel/bladder function/status. 7-26-16 Measures Put in Place: Mandatory education for all nursing staff on incontinence protocol for assessment and changes in function related to continence status.	

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F 315	Continued From page 31 the toilet. R290's care plan dated 4/22/16, indicated R290 independently ambulated, needed staff's assistance to use the toilet, but was usually continent of bladder. Staff interventions included offering the toilet with morning and night time cares, before and after meals. On 6/16/16, at 8:03 a.m. a nursing assistant (NA)-A stated she regularly provided care for R290. NA-A explained R290 typically came out of her room and looked for staff if she needed assistance. NA-A stated R290 was continent of urine and usually dry throughout the day shift. She wore a pull-up brief and was able to toilet herself. At 8:06 a.m. a licensed practical nurse (LPN)-B stated R290 was not on a toileting program and was continent of urine, but required stand by assistance from staff. LPN-B explained R290 had dementia which was becoming worse over time. In addition, the resident had been refusing staff's assistance and in fact had become aggressive toward staff. LPN-B was unsure when a bladder assessment had last been completed for R290. At 8:33 a.m. MDS coordinator (MDS)-A then explained R290's quarterly MDS dated 4/19/16, was changed to incontinent of urine. The change was due to staffs' documentation during the assessment period when the resident had been incontinent of urine three times on the day shift on 4/13/16, and on the evening shift on both 4/16 and 4/17/16. MDS-A stated staff had discussed whether the resident had experienced a significant change in her condition, but she had not actually met the criteria. The facility's system was to bring the information to the nurse	F 315	7-26-16 Monitoring Mechanism 15% random audits will conducted on all LTC residents for the next 90 days to monitor for any change in continence function/status. 7-26-16 8-26-16 9-26-16 Audits will be reviewed by the Quality Improvement Committee for compliance and competency of assessment for changes related to continence status. 7-27-16 8-31-16 9-30-16 Responsible Person/s Dir. of Staff Development Clinical Managers Dir. of Quality Improvement	

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F 315	Continued From page 32	F 315		

manager and director of nursing (DON) for input as to whether a resident had changed, and whether the care plan needed revision. MDS-A verified R290 did not have a comprehensive bladder assessment completed when a change was noted from incontinent of urine. MDS-A verified the the care plan was not changed on 4/22/16, to reflect urinary incontinence. MDS-A explained a comprehensive bladder assessment was completed at the time of a resident's admission or a significant change. The nurse verified R290 should have had a bladder assessment completed and care plan changes when she declined in her urinary status. MDS-A verified the resident had not had a medical reason (such as urinary tract infection) or been receiving medication that may have explained R290's increase in urinary incontinence.

At 9:22 a.m. MDS-A informed the surveyor that she had just talked to the staff on the unit who had informed her the resident was actually continent of urine. MDS-A stated that because of the conflicting information, a 3-day bladder assessment was being initiated to determine an accurate picture of the resident's bladder status.

Later that day at approximately 1:00 p.m. the DON stated that a 3-day bladder assessment should have been completed prior to revisions in R290's care plan.

The facility's Point of Care History--Bowel/Bladder worksheets completed by the NAs on all three shifts indicated between 1/21/16 and 5/19/16, noted R290 was incontinent 18 of 40 days, with four days unrecorded. The records showed R290 was also incontinent multiple times in one day and at various times throughout the day.

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F 315	Continued From page 33 A related policy was requested, but was not provided.	F 315		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure ice packs were not stored with food in a kitchenette on the transitional care unit, potentially affecting the 11 residents residing on the unit who may have utilized the freezer to store personal food items. . Findings included: During initial tour on 6/13/16, at 12:40 p.m. two long navy ice packs and one short blue ice pack were observed in the freezer in the kitchenette on the transition care unit (TCU). Food and beverages were also stored in the freezer. The assistant director of nursing (ADON) then verified the three ice packs were being stored in the freezer with food, some of which was opened (e.g. cake). The ADON explained the food belonged to individual residents, and stated, "We	F 371	F371: It is the policy of the Augustana Health Care Center of Minneapolis to store, prepare, and serve food in a sanitary manner. Corrective Action: Ice packs identified in the family lounge refrigerator were immediately discarded during the survey on 6-13-16 Identification of Other Residents: All facility refrigerators were audited for proper food storage, and removal of all ice packs. Signage was placed on all refrigerators stating no ice packs are allowed to be stored in the facility refrigerators. 7-14-16 Measures Put in Place: Mandatory education for all nursing staff	7/27/16

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F 371	Continued From page 34 need to get rid of these ice packs. We will need to throw away these open foods." The ADON stated the ice packs were reusable ice packs that residents may have put into the freezer, one of which the ADON verified was labeled with a resident name and room number. The ADON reported the ice packs probably should have instead been stored in a bag in the medication freezer, as residents utilized the ice packs on body parts such as hips and knees. During an interview with director of nursing (DON) on 6/17/16, at 11:15 a.m. she explained only disposable ice packs were used at the facility for residents. The DON explained occasionally residents brought their own with them from the hospital and then wanted to store them in the kitchenette freezer where resident food was also stored. The DON said she had instructed staff to not let residents store ice packs in the food freezer. The DON explained square ice packs were okay, as they were used to keep food cool and were not used on the body. The DON stated the facilty did not have a related policy.	F 371	on proper food storage to maintain sanitary conditions. 7-26-16 Mandatory education for all housekeeping staff assigned to deep clean facility refrigerators on proper food storage to maintain sanitary conditions. 7-26-16 A separate freezer for ice packs only was purchased for the TCU storage area with separate zip loc bags identified with resident name for individual storage of ice packs belonging to residents. 7-22-16 Monitoring Mechanism: Weekly audits of all facility refrigerators will be conducted for the next 30 days and monthly for the next 60 days to ensure proper storage of food items, and no storage of ice packs. All audits will be reviewed by the Quality Improvement Committee to ensure compliance with the proper storage of food and non-food items. 7-27-16 8-5-16 8-12-16 8-19-16 8-26-16 9-30-16 Responsible Person/s Dir. of Staff Development Dir. of Environmental Services Dir. of Quality Improvement 10-31-16	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		7/27/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245242	A. BUILDING _____ B. WING _____	06/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF MPLS	1007 EAST 14TH STREET MINNEAPOLIS, MN 55404

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F 431	Continued From page 35 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to properly store insulin pens on 2 of 5 nursing units observed, affecting four residents	F 431	F431 It is the policy of the Augustana Health Care Center of Minneapolis to properly	

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F 431	Continued From page 36 (R60, R115, R457, R458) who may have utilitzed the insulin. Findings include: Opened insulin pens were stored in the medication refrigerator on 6/13/16, at 2:22 p.m. when observed with a registered nurse (RN)-B. RN-A stated all insulin pens were kept in the refrigerator regardless of whether the insulin pens had been opened. Later that day at 7:50 p.m. RN-C stated all insulin pens were stored in the refrigerator after opening and had always been stored in that manner. RN-C stated there were four current residents who required insulin residing on 1 main. RN-C verified the following was stored in the medication refrigerator: 1) R67's opened insulin Novolog pen dated 6/5/16, with about 7-8 units left of the 250 units. The orange label on the pen gave instruction to store the medication at room temperature after opening. 2) R458's Novolog pen with an opened date of 6/8/16, with 170 of 250 units remaining. 3) R60's medication had been opened, but had not been dated when it was opened. The medicaiton had an expiration date of 5/31/16 with 250 of 250 units remaining. RN-C stated he planned to discard the medication, as it had been discontinued. 4) R457's Novolog pen was opened with no opened date and 250 of 250 units remained. RN-C said the resident had discharged from the facility, but the medicaiton had not yet been discarded.	F 431	store and label all drugs and biologicals. Corrective Action: All improperly stored insulin pens were discarded during the survey as identified by surveyor. 6-14-16 Identification of Other Residents: All other nursing units were checked for proper storage of insulin pens during the survey to ensure compliance 6-14-16 Measures Put in Place: Mandatory education for all nursing staff on proper storage of insulin pens. 7-26-16 Monitoring Mechanism: Weekly audits of medication carts and med rooms will be conducted for the next 30 days, and monthly for the following 60 days to ensure proper storage of medications. 7-27-16 8-5-16 8-12-16 8-19-16 8-26-16 9-30-16 10-31-16 All audits will be reviewed by the Quality Improvement Committee for compliance with facility policy for storage of medications. 7-27-16 8-31-16 9-30-16 Responsible Person/s Dir. of Staff Development Clinical Managers Dir. of Quality Improvement	

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F 431	Continued From page 37 During interview with director of nursing (DON) on 6/17/16, at 11:15 a.m. the DON verified unopened insulin pens were stored in the refrigerator. Once opened, they were to be dated and then stored in the medication cart. The DON stated manufacturer's instructions for storage for insulin pens directed storing at room temperature once the medicaiton was opened, and the medication was viable for 28 days once opened. The DON stated vials of opened insulin could be stored at room temperature or in the refrigerator, but going forward, a good system/process would be to store both vials of insulin and pens in the medication cart once they were opened. Manufacturer's instructions for Novolog directed insulin pens to be stored only at room temperature.	F 431		

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	245242	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/23/2016**

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AUGUSTANA HCC OF MPLS	**1007 EAST 14TH STREET** **MINNEAPOLIS, MN 55404**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Divisions, on June 23, 2016. At the time of this survey, Augustana Health Care Center of Minneapolis 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/14/2016

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.

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Augustana Health Care Center of Minneapolis is a 5-story building with a basement. The building was constructed at 3 different times. The original building was constructed in 1945 and was determined to be of Type II(222) construction. In 1968, an addition was constructed to the South side of the building that was determined to be of Type II(222) construction. In 1974, an addition was constructed to the West side of the building that was determined to be of Type II(222) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 290 beds and had a census of 268 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is	K 000		

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to maintain smoke/fire barrier doors in accordance with LSC 19.3.7.5. This deficient practice could affect 52 residents. Findings include: On a facility tour between the hours of 09:00 AM and 02:00 PM on June 23, 2016, observation revealed that there was not a smoke detector within 5 feet of the smoke barrier doors, that are held open my a magnetic hold-open device, on 2nd floor east, between rooms 268 and 269. This deficient practice was verified by the Administrator at the time of the inspection.	K 027	K027 It is the policy of the Augustana Health Care Center of Minneapolis that all areas are properly equipped with smoke detectors. Corrective Action: On 7/11/16 an additional smoke detector was added in the identified area between room 268E and 269E per 2567. Monitoring Mechanism: Building has on-going monitoring through regularly scheduled maintenance rounds, and monthly Quality Improvement rounds to ensure proper placement of all needed fire safety equipment. 7-27-16 Responsible Person Director of Maintenance	7/27/16
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A,	K 067		7/27/16

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K 067	Continued From page 3 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and staff interviews, it could not be verified that the facility's general ventilating and air conditioning system (HVAC) is installed in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11. A noncompliant HVAC system could affect all 268 residents. Findings include: On a facility tour between the hours of 09:00 AM and 02:00 PM on June 23, 2016, observation revealed that the ventilation system for the main building appears to be utilizing the egress corridor as an air plenum for the resident rooms. This deficient practice was verified by the Administrator at the time of the inspection.	K 067	F067 See attached waiver and supporting documents for K067	

K 067

The building heating, ventilation and air conditioning equipment (HVAC) does not comply with LSC (00) Section 9.2, and NFPA 90A, 1999 Ed., because the corridors are being used as a plenum.

An annual/continuing waiver is being requested for K067.

A. Compliance with this provision will cause an unreasonable hardship because:
1. The most recent cost estimate dated March 31, 2016 for a complying ducted HVAC system is $1,900,000.00 (See attached letterhead from Metropolitan Mechanical for costs and scope of project work)
2. This project would displace residents for several months, many would need to be transferred out to other facilities as we rarely have available beds in the facility due to census of 92% as a monthly average. This displacement of residents would cause significant emotional distress to residents which could also affect their physical health status in many cases
3. Other projects that would need to occur to support this HVAC system replacement include but are not limited too:
   a. The building electrical system would need to be upgraded to support a new ducted system.
   b. The system would also require a new meter at additional costs to the ducted HVAC bid.
   c. Installation of a ducted system would require asbestos abatement which would also increase the cost.

   Under the current CMS reimbursement system our costs could not be re-coup as we currently operate at a loss.
4. Due to these extensive costs, disruption and possible relocation of residents there are no immediate plans to implement the above major physical plant renovation. In addition to the extra associated projects and costs, the ducted system would need to penetrate load bearing walls decreasing building structural integrity.
5. The building is currently 55 years old and not slated for replacement in the foreseeable future. The building has a useful life of an additional 75+ years and meets all LSC to ensure a safe physical environment for residents and staff, which in turn allows the existing non-complying HVAC to remain in use..

B. There will be no adverse effect on the building occupant's safety in accordance with SOM 2480B because:
1. The facility is Type II with an interior finish rating of Class A.
2. The walls, floors, ceiling and vertical openings resist the passage of smoke
3. The following safety features are installed:
   a. Fire Alarm EST-3 addressable, transmission type SD4 Version 5.2
   b. The building is protected by a complete fire sprinkler system that complies with NFPA 13, 1199 Ed. As of January 2008. (Fully (sprinkled, wetpipe quick response)
   c. Fire extinguishers – Dry chemical 4-A 60-BC
   d. The building is equipped with an approved, addressable fire alarm/smoke detector system, and all resident rooms are equipped with automatic smoke detection tied into the nurses call station.
4. In accordance with LSC 19.7.2.2, the facility has a compliant fire safety plan which included fire plans for all departments and employees, training on plans is conducted upon hire, and annually for all employees. Fire drills are conducted at least quarterly on each shift.
5. Operational plans include: Plans for all departments, and all office areas, Fire Out, Fire Drills, Fire Watch Alarms Out, Fire Watch Sprinkler systems out.
6. The facility sets a staff ratio at 3.70 nursing hours per day per resident.
7. There are 5 smoke compartments on Ground Floor, 1st, 2nd, and 3rd floor, 4 smoke compartments on 4th floor, and 3 on 5th floor Main which is currently closed
8. TCU residents are located on the first floor of both the East and Main building and houses 53 residents, the dementia care unit is located on 4th floor Main and houses 28 residents
9. The closest fire department is 1 mile away and has an average of 5 minutes or less response time.

APPROVED
By Tom Linhoff at 12:33 pm, Jul 14, 2016

7/14/16

Administrator 7/14/16