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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: X8U4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00979

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245264**
2.STATE VENDOR OR MEDICAID NO.
(L2) **176622800**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA HCC OF APPLE VALLEY**
(L4) **14650 GARRETT AVENUE**
(L5) **APPLE VALLEY, MN** (L6) **55124**

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) **01/25/2006**

6. DATE OF SURVEY **2/7/2018** (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 **178** (L18)
13.Total Certified Beds **178** (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)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	178			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Pamela Manzke, HFE NE II 2/20/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 02/20/2018 (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
07/01/1983
(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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245264
February 20, 2018

Mr. David Shaw, Administrator
Augustana Home Care Center of Apple Valley
14650 Garrett Avenue
Apple Valley, MN 55124

Dear Mr. Shaw:

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 January 22, 2018 the above facility is certified for:

178 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 178 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered

February 20, 2018

Mr. David Shaw, Administrator
Augustana Health Care Center of Apple Valley
14650 Garrett Avenue
Apple Valley, MN 55124

RE: Project Numbers S5264027, H5264070

Dear Mr. Shaw:

On December 20, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective December 25, 2017. (42 CFR 488.422)

In addition, on December 20, 2017, we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies be imposed:

- Civil money penalty for the deficiency cited at F689. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on December 4, 2017 that included an investigation of complaint number H5264070. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On February 7, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on January 24, 2018 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 December 4, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 22, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 4, 2017, as of January 22, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective January 22, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of December 20, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Civil money penalty will remain in effect. (42 CFR 488.430 through 488.444)

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: X8U4

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(L4) **14650 GARRETT AVENUE**
(L5) **APPLE VALLEY, MN** (L6) **55124**

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) **01/25/2006**

6. DATE OF SURVEY **12/04/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	178			
(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 12/27/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 02/09/2018 (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
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3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
07/01/1983
(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
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03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
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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

CCN: 24 5264

On December 4, 2017, a standard survey was completed at this 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 the facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required. In addition, at the time of the December 4, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5264070 that was found to be substantiated at F0689

Your facility meets the criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective December 25, 2017. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F0689. (42 CFR 488.430 through 488.444)

Refer to the CMS 2567 for health and life safety code along with the facility's plan of correction.

Electronically delivered

December 20, 2017

Mr. David Shaw, Administrator
Augustana Health Care Center of Apple Valley
14650 Garrett Avenue
Apple Valley, MN 55124

RE: Project Number S5264027, H5264070

Dear Mr. Shaw:

On December 4, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required. In addition, at the time of the December 4, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5264070 that was found to be substantiated at F0689.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

Potential Consequences - the consequences of not attaining substantial compliance 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:

Susie Haben, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susie.haben@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; **OR**
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; **OR**
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; **OR**
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey **OR** deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; **OR**
- A facility is classified as a Special Focus Facility (SFF) **AND** has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

• State Monitoring effective December 25, 2017. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Civil money penalty for the deficiency cited at F0689. (42 CFR 488.430 through 488.444)

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

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 remedy be imposed:

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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.

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 March 4, 2018 (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 June 4, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

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

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
	245264	A. BUILDING _____ B. WING _____	12/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	**14650 GARRETT AVENUE APPLE VALLEY, MN 55124**

(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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted December 1, 2017 during a recertification survey. 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. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted 11/28/17 through 12/4/17, and a complaint investigation was also completed at the time of the standard survey. At the time of the survey, an investigation of complaint #H5264070 was completed and found to be substantiated at F689. 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. 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/21/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	12/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	**14650 GARRETT AVENUE APPLE VALLEY, MN 55124**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 form. Your electronic submission of the POC will be used as verification of compliance	F 000		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.	F 582		1/22/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	12/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

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F 582	Continued From page 2 (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide 48-hour notice for the end of Medicare coverage for 4 of 4 residents (R289, R290, R291 and R292) reviewed for liability notices. Findings include: A review of four resident records of persons no longer eligible for Medicare coverage revealed residents R289, R290, R291 and R292 who had been receiving services under Medicare were not provided appropriate notice of non-coverage to indicate the resident or legal representative could request a reconsideration, Demand Bill, once Medicare services were no longer being received or necessary. On 11/30/17, at 2:37 p.m. registered nurse stated the facility did not have documentation which	F 582	F582 It is the policy and expectation of Augustana Health and Rehab of Apple Valley to provide 48 hour notice of non-coverage to residents when their Medicare coverage is ending. Identification of other residents: An audit was completed of other residents whose Medicare coverage ended and remained in the facility over the past year. Measures put in place: Medicare nurse re-educated on the policy for issuing appropriate notices of non-coverage 48 hours prior to the end of Medicare coverage. Monitoring Mechanisms: To prevent recurrence, audits will be conducted monthly for 2 months on 5 residents whose Medicare coverage	

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	245264	A. BUILDING _____ B. WING _____	12/04/2017

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F 582	Continued From page 3 would indicate R289, R290, R291 and R292 received their denial notices. On 12/01/17, at 10:38 a.m. director of nursing stated her expectation was that the correct process for Medicare beneficiary notification with regard to residents being informed regarding continued or non-continued Medicare benefits, would follow the facility's policy and procedures which indicated the notifications should be provided.	F 582	ended to ensure ongoing compliance with this practice. Results of the audits will be reviewed by the QAPI committee. DON Responsible for compliance. Date of completion 1/22/18	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		1/22/18

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F 656	Continued From page 4 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to prevent accidents for 1 of 4 residents (R238) reviewed for accidents. Findings include: R238's care plan dated 8/8/17, included 30-minute safety checks with offer to toilet when awake in an effort to help eliminate falls. However, this revision hadn't been transferred to the NA Assignment Sheet. On 12/1/17, at 1:52 p.m. R238 was observed lying on top of his bed with the tv on until 2:17 p.m. During the observation a 30-minute check by staff was observed to be completed. However, during the observation R238 was not offered or assisted to the bathroom. On 12/1/17, at 4:05 p.m. NA-C stated she	F 656	F656 It is the policy and expectation of Augustana Health and Rehab of Apple Valley to implement all necessary interventions to prevent accidents. Immediate Corrective action: Information regarding 30 min safety checks with offers to toilet when awake was added to NA assignment sheet on 12/8/17 Clinical manager was re-educated on ensuring that all fall prevention interventions are included on the NA assignment sheets. Toileting patterns reviewed and new bowel and bladder observation was completed on 12/21/17. Identification of other residents: An audit was conducted of NA assignment sheets compared to falls/safety plan of care to assure that necessary fall	

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F 656	Continued From page 5 checked on R238 every 30-minutes safety checks. NA-C stated she did not ask R238 if he wanted to go to the bathroom during the safety checks because staff "knew" R238 would ask staff and would call for help. NA-C showed surveyor documentation on R238 on the kiosk and verified the care plan on the wall stated to "offer bathroom [to R238] while awake during 30-minute safety checks". NA-C stated she had not noticed this before nor known R238 was care planned for "offer to toilet every 30 minutes while awake" and stated she thought it would be good to put that fall intervention on the NA assignment sheets to ask R238 if he wanted to use the bathroom during the safety check stating because the NA assignment sheets was what the NAs followed for R238's plan of care. On 12/1/17, at 4:23 p.m. NA-D stated she was taking care of R238 today and stated she followed the NA assignment sheets, that R238 had 30-minute safety checks and she would document at end of shift on the kiosk. -D stated R238 was dry most of the time. NA-D stated during safety check she did not ask R238 if he wanted to go to the bathroom but stated R238 called for help. On 12/1/17, at 4:42 p.m. RN-B stated the interdisciplinary team (IDT) met every day Monday through Friday except Tuesdays when just nursing staff would meet to discuss falls. RN-B stated the nurse managers will put first intervention in place and then talk to team and possibly add more fall interventions. RN-B stated the 8/8/17, safety checks with toilet every 30 minutes and three-day diary for toileting pattern was an older intervention from before R238 came to second floor from third floor. RN-B stated anti	F 656	prevention interventions were on the NA assignment sheets. Measures put in place: Clinical Nurse Managers will bring copy of NA assignment sheet to IDT to assure interventions are current with plan of care. Monitoring Mechanisms: To prevent recurrence, audits will be conducted weekly for 2 months on 5 residents to ensure that interventions to prevent falls are included on the NA assignment sheets. Results of these audits will be reviewed by the QAPI committee. DON responsible for compliance. Date of completion 1/22/18	

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F 656	Continued From page 6 roll backs had not been placed on R238's w/c as the falls were really not about R238's w/c but about the toilet. Five minutes later assistant DON (ADON) came up to RN-B's office and stated the fall intervention for the incident on 8/5/17, was care planned under topic Falls for 30-minute safety checks with offer of toileting when awake. RN-B sitting near stated she had not realized it was a toileting intervention as it was listed under falls in the care plan and not under toileting. RN-B stated that was why she had not included "offer to toilet every 30 minutes when awake" in the NA assignment sheets when she updated them 9/5/17. The ADON stated she would re-educate the staff to correct the process. The ADON stated R238 had been given the urinal as a fall intervention but R238 really did not want the urinal. RN-B stated she had not completed any three-day toileting diary since R238 came to third floor and the first day of the three-day toileting diary had been put out a couple of days ago (had not been completed by staff). On 12/4/17, at 9:42 a.m. RN-B explained again she had not seen the "offer to toilet when awake" safety checks that had been care planned in 8/17, as it had been care planned under falls and "not toileting" and just "had not clicked" with her when reading the fall intervention. RN-B explained R238 had come to 2nd floor on 8/23/17, after the "offer to toilet" every 30 minutes had been implemented.	F 656		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a	F 686		1/22/18

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F 686	Continued From page 7 resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess risk factors to determine interventions for an unavoidable stage 3 pressure ulcer (defined as full thickness tissue loss, with subcutaneous fat that may be visible but bone, tendon or muscle is not visible) for 1 of 1 resident (R21) reviewed for pressure ulcer. Findings include: R21's record was reviewed and identified an admission date of 9/2016. The undated facesheet identified current diagnoses as: adult failure to thrive, nutritional anemia, weakness, hypothyroidism, chronic knee pain, symptoms and signs involving cognitive functions and awareness, restlessness and agitation. R21's most current quarterly Minimum Data Set (MDS) assessment dated 9/4/17, indicated R21 had one stage 3 pressure ulcer and one stage 4 pressure ulcer (defined as full thickness tissue loss with exposed bone, tendon or muscle). The prior quarterly MDS dated 6/12/17, identified the same. A Comprehensive Wound Assessment dated	F 686	F686 It is the policy and expectation of Augustana Health and Rehab of Apple Valley to comprehensively re-assess residents if they develop a new pressure injury. Immediate Corrective Action: A new comprehensive skin assessment was completed on 12/8/17 to include assessment and comprehensive wound summary progress note. Identification of other residents: An audit was conducted of other residents with facility acquired pressure injuries to confirm that they have had the necessary comprehensive skin assessments and comprehensive wound summary progress notes completed. Measures put in place: Clinical nurse managers were re-educated on the policy regarding completion of a new comprehensive skin assessment any time a resident develops	

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F 686	Continued From page 8 12/23/16, identified that R21 had acquired "pressure injury on coccyx", and identified potential contributing factors; "This open area is considered to be unavoidable due to diagnosis of failure to thrive, resident refusal of cares, repositioning and food. The patient scored 11 out of 23 on the Braden Scale risk assessment on 12/23/16, indicating high risk for developing pressure ulcers and/or skin alterations. Higher areas of risk include sensory perception, moisture due to urinary and bowel incontinence, activity/mobility due to requiring extensive assist with activitity of daily living (ADL) , requiring use of lift with transfers. Tissue tolerance evaluation indicated that the patient is able to tolerate Q (every) 1 hour repositioning due to pressure ulcers while repositioning side to side avoiding the coccyx." . The interventions included bilateral heel boots/ heel elevation while in bed and pressure redistribution mattress to bed and redistribution cushion to wheelchair. The comprehensive assessment did not identify any issues with R21's right ankle and/or potential contributing factors. During observation and interview on 11/30/17, at 1:10 p.m. R21 was observed in bed, laying on back, on a pressure redistribution air mattress with the head of the bed elevated. R21 was unable to answer questions regarding history of pressure ulcers, current treatment or interventions. On the same day at 3:23 p.m., nursing assistant (NA)-F was observed to change R21's incontinent brief and provide incontinent care. A clean and dry dressing was observed to be in place on R21's coccyx. NA-F assisted R21 with turning to the right side and positioned a wedge cushion behind R21's back. R21 was observed to have boots on both feet with a kerlix	F 686	a new pressure injury. Monitoring Mechanisms: Audits will be conducted monthly for 3 months on any residents who develops a new pressure injury to ensure that the comprehensive skin assessment and comprehensive wound summary progress note was completed. Results of these audits will be reviewed by the QAPI committee. DON responsible for compliance. Date of completion: 1/22/18	

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F 686	Continued From page 9	F 686		

wrap upon right ankle.

During observations on 12/1/17, at 10:45 a.m. licensed practical nurse (LPN)-I was in R21's room preparing to do a pressure ulcer treatment for R21 who was in bed. R21 declined to allow the surveyor observe the treatments to the right ankle and coccyx area.

During interview on 12/01/17, at 4:02 p.m. with registered nurse (RN)-K and RN-J, they stated R21 had been assessed as being at risk for pressure ulcers at the time of admission, and interventions had been implemented. However, they stated R21 developed a stage 4 pressure ulcer on 11/15/16, and a stage 3 pressure ulcer to the right ankle on 2/15/17. The RNs further stated comprehensive skin assessments were supposed to be completed at the time of any new pressure ulcer development, but confirmed this had not occurred.

During interview with RN-A and RN-J on 12/4/17, at approximately 11:30 a.m. they verified R21 had developed a stage 3 pressure ulcer to the right ankle on 2/15/17 however, stated the area had been being monitored as a "scab" prior to the stage 3 pressure ulcer development. The RNs confirmed staff should have completed a comprehensive skin assessment at the time the new pressure ulcer was identified but confirmed this had not been done.

A care area assessment (CAA) for pressure ulcers dated 12/29/16, indicated R21 had a stage 4 pressure ulcer on the coccyx which had not been present at the time of admission. The CAA identified risk factors for pressure ulcers including impaired mobility, cognitive loss, incontinence,

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F 686	Continued From page 10	F 686		

malnutrition, terminal illness, depression, decline in ADL's (activities of daily living), and indicated R21 required regularly scheduled reposition, a special mattress on the bed, a cushion on the wheelchair seat to reduce or relieve pressure, and to proceed to care plan.

R21's current care plan dated 11/20/17, identified R21 as being at risk for pressure ulcers, related to current stage 4 pressure ulcer on coccyx and stage 3 pressure ulcer to right ankle, poor nutrition, mechanical forces (friction/shear), altered sensation, impaired mobility, moisture exposure, activity level. Other risk factors identified included low body mass indicator (BMI), pain, pronounced bony prominences, incontinence, advanced age, refusal of cares, and refusal to eat. Interventions included: wear heel boots at all times, prefers to wear only the right ankle boot, prefers to stay in bed and will frequently refuse to get up in the chair, has been educated on the risks verses benefits, pressure redistribution air mattress, check functions, check cleanliness and functioning daily, assess pain and medicate with analgesic prior to dressing change/therapy as ordered by care provider, assess skin alteration every shift, ensure dressing is in place and peri wound is intact to location: coccyx/IT (ischial tuberosity) and right ankle, measure area weekly, update nurse practitioner/medical doctor (NP/MD) , dietary, resident family monthly or with any decline in wound healing and skin treatment per MD orders.

R21's most current Braden scale score (assessment tool used to identify risk of development of pressure ulcers) dated 11/25/17, indicated total score of 11 (10-12 is high risk) indicating R21 was at high risk for pressure ulcer

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F 686	Continued From page 11	F 686		

development. The previous Braden scale dated 9/25/17, indicated a score of 12 also indicating R21 as being at high risk for pressure ulcers.

Review of Progress Notes (PN) revealed:
PN dated 2/15/17- written by registered nurse (RN-)-L "Writer provided wound care to open area on right ankle."
PN dated 3/2/17, written by RN-J indicated "Area to right upper ankle 1.5 cm [centimeter] x 2 cm. Wound bed is red, no drainage noted. Edges to wound well approximated. No odor noted."
PN dated 3/17/17, written by RN-J indicated "Wound Measurement-R [right] Ankle 2.5 cm x 1.5 cm, serosanguinous drainage present, no odor noted."

R21's wound documentation flow sheets for the time period of 12/1/16 through 12/1/17, revealed weekly wound documentation starting on 4/6/17, which identified area on right ankle as a stage 3 pressure ulcer. The wound was assessed on the following dates; 4/13/17, 4/20/17, 4/27/17, 5/4/17, 5/11/17, 5/18/17, 5/25/17, 6/1/17, 6/8/17, 6/15/17, 6/26/17, 7/1/17, 7/6/17, 7/13/17, 7/20/17, 7/27/17, 8/3/17, 8/10/17, 8/17/17, 8/25/17, 9/1/17, 9/7/17, 9/15/17, 9/21/17, 9/28/17, 10/5/17, 10/12/17, 10/19/17, 10/26/17, 11/3/17, 11/9/17, 11/16/17, 11/22/17 and 11/29/17.

R21's treatment orders included an order dated 11/1/17, for wound care: apply to right outer ankle: Calcium Alginate (fibers derived from brown seaweed or kelp for wound treatment) to wound. Cover with gauze and wrap twice a day.

R21's Skin Assessment Risk dated 3/16/17, included: 'Have the risk factors for developing pressure injures changed since the last

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F 686	Continued From page 12 comprehensive Skin Assessment/Braden?': Documentation in response indicated, "blanchable redness coccyx". The form did not address the open area on R21's right ankle. Further review of the record revealed no further comprehensive skin assessments were completed to identify potential contributing factors and develop interventions related to R21's stage 3 pressure ulcer of the right ankle. The facility's Skin Care Program policy revised 7/17, indicated: "A new Augustana Skin Assessment with Braden Scale will be completed annually and with a Significant Change or upon discovery of a new pressure ulcer; venous, arterial, diabetic, neuropathic; or mixed etiology. Tissue tolerance testing (sitting and laying) is completed upon admission, upon discovery of a new pressure injury and with a significant change of status. " .	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 689	F689	1/22/18

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F 689	Continued From page 13 review, the facility failed to implement fall interventions for 2 of 4 residents (R238, R20) reviewed for accidents. This resulted in harm for R238 who experienced frequent falls and sustained fractures of the left wrist. Findings include: R238 was observed on 11/28/17, at 7:55 p.m. lying on his bed with his left arm in a cast and sling. On 11/30/17, at 3:44 p.m. R238 was observed lying on top of his bed watching television (tv) with the head of the bed slightly elevated, call light wrapped around grab bar on the exit side of the bed, and a wheelchair (w/c) with a dycem (non-slip material) observed on the seat approximately three to four feet from the bed. There was no floor matt observed near R238's bed. On 12/1/17, at 7:30 a.m. R238 was observed lying on the top of his bed with the head of the bed slightly elevated. The call light cord was observed to be wrapped around the grab bar of the bed, and the w/c with dycem cushion was again approximately three to four feet away from the bed. There was no floor matt observed near R238's bed. On 12/1/17, at 1:52 p.m. R238 was observed lying on top of his bed with the tv on until 2:17 p.m. During the observation a 30-minute check by staff was observed to be completed. However, during the observation R238 was not offered or assisted to the bathroom. On 12/1/17, at 2:37 p.m. R238 was observed	F 689	It is the policy and expectation of Augustana Health and Rehab of Apple Valley to implement all necessary interventions to prevent accidents. Immediate Corrective action: Information regarding 30 min safety checks for R238 with offers to toilet when awake was added to NA assignment sheet on 12/8/17. Toileting patterns reviewed and new bowel and bladder observation was completed on 12/21/17. Fall prevention interventions were added to NA assignment sheet for R20. Clinical manager was re-educated on ensuring that all fall prevention interventions are included on the NA assignment sheets. Identification of other residents: An audit was conducted of NA assignment sheets compared to falls/safety plan of care to assure that necessary fall prevention interventions were on the NA assignment sheets. Measures put in place: Clinical Nurse Managers will bring copy of NA assignment sheet to IDT to assure interventions are current with plan of care Monitoring Mechanisms: To prevent recurrence, audits will be conducted weekly for 2 months on 5 residents to ensure that interventions to prevent falls are included on the NA assignment sheets. Results of these audits will be reviewed by the QAPI committee.	

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F 689	Continued From page 14 lying on top of his bed wearing grippy socks. A concave mattress was observed on the bed, and the w/c with dycem in place was observed to be three to four feet from the bed. No floor mat was observed on the floor by R238's bed, but was instead observed between the bathroom door and dresser. An Incident Report for R238 dated 11/24/17, indicated R238 had fallen on 11/24/17, at approximately 1040 (10:40 a.m.) The report indicated R238 had been found on the floor by the bathroom after having transferred himself without use of the call light. The notes indicate a call light had been activated by R238's roommate. Upon staff assessment of the resident, R238's wrist appeared to be out of alignment and he complained of pain. The facility staff sent R238 to the emergency room (ER), and he returned with a diagnoses of re-fractured wrist. The facility's Fall Scene Investigation Report dated 11/24/17, indicated R238 was found on the floor by the bathroom door on 11/24/17, at 10:45 a.m. and had been last toileted at 0930 (9:30 a.m.) Same report indicated to assess R238's toileting schedule. A Progress Note dated 11/24/17, indicated R238 had fallen on 11/24/17, at approximately 10:40 a.m. and the PN noted R238 had hit his head at the scene and noted R238's left wrist to be dislocated with swelling and pain to the site. Same PN indicated R238 had previous fracture to the left wrist and patella (knee) from falls at the facility and also indicated toileting schedule would be assessed and urinal offered at bedside (the assessment was not completed). Following this fall, an intervention was identified to institute a	F 689	DON responsible for compliance. Date of completion 1/22/18	

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F 689	Continued From page 15 three day toileting diary. On 11/29/17, at 10:52 a.m. registered nurse (RN)-B stated R238 routinely attempted self-transfers, and had been found on the floor in his room on 11/24/17, when he had refractured his wrist form a previous break in August of 2017. On 11/30/17, at 1:40 p.m. nursing assistant (NA)-A stated R238 had transferred to the unit from the transitional care unit about four to five months ago and that he required one staff transfer assist. NA-A stated R238 had fallen and broken his arm at the facility. NA-A stated R238 was a fall risk and his balance was not stable. The NA further stated R238 required frequent checks and staff needed to respond to R238 right away when he put his call light on. NA-A stated R238 puts on his call light but "gets impatient and cannot wait and takes himself to the bathroom." Upon review of the incident information from 8/5/17, the following was noted: An Event Report dated 8/6/17, indicated R238 had fallen on 8/5/17 at 1:30 p.m. and had been sent to the ER for evaluation. The report does not indicate any injury identified as a result of the 1:30 p.m. fall. However, the report also indicated the resident had fallen at 8:00 p.m. due to continued attempts to self-ambulate to the bathroom. As a result of the 8:00 p.m. fall, the resident had complaints of pain in his left wrist and had limited range of motion in the wrist. An x-ray obtained the following morning, revealed a fracture to the wrist. The facility's Fall Scene Investigation Report following the fracture, indicated staff were to implement every 30-minute safety checks with an offer to toilet the resident	F 689		

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F 689	Continued From page 16	F 689		

when awake. Additional interventions included to keep personal items within reach and to initiate a toilet diary in order to determine an individualized pattern of elimination.

R238's care plan dated 8/8/17, had been updated to include the need for 30-minute safety checks with offer to toilet when awake. However, this revision hadn't been transferred to the NA Assignment Sheet.

R238's quarterly Minimum Data Set (MDS) dated 8/30/17, indicated R238's cognition was moderately impaired, with poor decision making with cues/supervision required, and one staff limited assistance required with transfers and toileting. Same MDS also indicated R238 was not steady, was only able to stabilize with human assistance when moving from seated to standing, walking, turning, and moving on and off the toilet. The MDS indicated R238 was not on a toileting program and did not reject cares. R238's same MDS had fractures and pain present at time of assessment with the pain scale placed at '7' of '10' (10 being the highest level of pain) on the pain scale, frequent pain with pain limiting daily activities, and requiring pain medication regimen and prn (as needed) pain medications.
(R238's 14-day MDS dated 6/8/17, indicated R238 had no pain.)

Review of progress notes and Event Reports indicated R238 had 7 additional falls between 8/5 and 11/24/17. Although numerous interventions had been identified, the resident did not have a bladder diary conducted to determine an individualized toileting plan.

On 12/1/17, at 2:39 p.m. RN-B stated most of

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F 689	Continued From page 17 R238's falls were about R238 having to go to the toilet. RN-B stated R238 walks, thinks he can make it to the bathroom, wants to be independent, but needs to continue to be reinforced by staff to ask for assistance. RN-B stated R238 had impaired cognition and recently a psychology assessment ordered. On 12/1/17, at 4:05 p.m. NA-C stated R238 had therapy and stated a week before Thanksgiving she had seen R238 walking in his room and had reminded him he needed staff assistance. NA-C stated R238 had replied back to her, "This is what I am supposed to be doing" and stated the next day he fell and re-fractured his wrist. NA-C stated she checked on R238 all the time, watched him, reminded him to use his call light. NA-C stated after R238 falls he remembers for a while to use his call light and then goes back to walking on his own. NA-C stated R238 had dycem on his w/c, concave mattress, call light in reach and safety checks. NA-C stated R238 did not want his floor mat on the floor. NA-C stated she checked on R238 every 30-minutes safety checks. NA-C stated she did not ask R238 if he wanted to go to the bathroom during the safety checks because staff "knew" R238 would ask staff and would call for help. NA-C showed surveyor documentation on R238 on the kiosk and verified the care plan on the wall stated to "offer bathroom [to R238] while awake during 30-minute safety checks". NA-C stated she had not noticed this before nor known R238 was care planned for "offer to toilet every 30 minutes while awake" and stated she thought it would be good to put that fall intervention on the NA assignment sheets to ask R238 if he wanted to use the bathroom during the safety check stating because the NA assignment sheets was what the NAs followed for R238's	F 689		

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plan of care. NA-C stated R238 was very private and she would step out of the bathroom into R238's room while R238 voided and then would assist R238 with his clothing.

On 12/1/17, at 4:23 p.m. NA-D stated she was taking care of R238 today and stated she followed the NA assignment sheets, that R238 had 30-minute safety checks and she would document at end of shift on the kiosk. NA-D stated R238 did not want the floor mat and stated R238 needed one staff assistance to the toilet and that she would step out of the bathroom and stay in room to give R238 privacy and go back and help with his clothes. NA-D stated R238 was dry most of the time. NA-D stated during safety check she did not ask R238 if he wanted to go to the bathroom but stated R238 called for help.

On 12/1/17, at 4:42 p.m. RN-B stated the interdisciplinary team (IDT) met every day Monday through Friday except Tuesdays when just nursing staff would meet to discuss falls. RN-B stated the nurse managers will put first intervention in place and then talk to team and possibly add more fall interventions. RN-B stated the 8/8/17, safety checks with toilet every 30 minutes and three-day diary for toileting pattern was an older intervention from before R238 came to second floor from third floor. RN-B stated anti roll backs had not been placed on R238's w/c as the falls were really not about R238's w/c but about the toilet. Five minutes later assistant DON (ADON) came up to RN-B's office and stated the fall intervention for the incident on 8/5/17, was care planned under topic Falls for 30-minute safety checks with offer of toileting when awake. RN-B sitting near stated she had not realized it was a toileting intervention as it was listed under

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F 689	Continued From page 19 falls in the care plan and not under toileting. RN-B stated that was why she had not included "offer to toilet every 30 minutes when awake" in the NA assignment sheets when she updated them 9/5/17. The ADON stated she would re-educate the staff to correct the process. The ADON stated R238 had been given the urinal as a fall intervention but R238 really did not want the urinal. RN-B stated she had not completed any three-day toileting diary since R238 came to third floor and the first day of the three-day toileting diary had been put out a couple of days ago (had not been completed by staff). On 12/4/17, at 9:42 a.m. RN-B explained again she had not seen the "offer to toilet when awake" safety checks that had been care planned in 8/17, as it had been care planned under falls and "not toileting" and just "had not clicked" with her when reading the fall intervention. RN-B explained R238 had come to 2nd floor on 8/23/17, after the "offer to toilet" every 30 minutes had been implemented. RN-B explained the safety checks staff were to have "eyes on him, anticipate his needs" as R238 was "impulsive and gets out of his bed and chair himself." On 12/4/17, at 10:55 a.m. the director of nursing (DON) stated when a resident fell the nurse working looked to see if there was an immediate intervention that was needed to be put in place. The nurse would initiate the incident, begin documenting in Matrix (electronic health record) in the computer, and the physician would be notified. Falls are reviewed each morning in the IDT stand up and the team would discuss how it happened, what the resident is trying to tell us, and "how we can prevent it [falls] in the future." The DON stated, the IDT would try to do an	F 689		

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alternative, figure out was the resident trying to go to the toilet, and then would care plan the intervention. The DON stated the fall intervention should "be put in place the same day." The DON remarked the nurse managers, ADONs (assistant director of nursing), social workers, therapeutic recreation staff, or whoever was owning the incident, should care plan and follow up with it. The DON expected staff to follow the residents' care plans and the NA Assignment Sheets so when an NA is in the resident's room, the NAs know what cares are to be provided for the resident. The DON commented the NA Assignment Sheets should be consistent with the resident care plan available at the kiosks. The DON stated a toileting pattern for R238 was used as a fall intervention and the summary of the three-day toileting diary should be in his Progress Notes. DON stated with focus charting she would expect staff to know where to look.

On 12/4/17, at 11:24 a.m. DON stated 30 minute checks were safety checks because a resident had fallen. She stated staff are to visually look at the resident to see if the resident is safe and intervene if necessary.

The facility failed to adequately communicate fall interventions to staff to ensure implementation of planned interventions for R20.

R20's most current annual MDS assessment dated 9/4/17, identified R20 had moderately impaired cognition, required limited assistance of one with bed mobility, transfers, walking, dressing, toilet use and personal hygiene and had no falls since prior MDS or admission.

R20's CAA for falls, dated 9/4/17, identified R20

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had risk factors for falls including impaired mobility, balance, incontinence, cognitive impairment, anxiety, and depression, proceed to care plan.

R20's care plan dated 10/6/17, indicated R20 was at risk for falls r/t weakness, dementia, atrial fibrillation, iron deficiency anemia, arthritis, systolic (congestive) heart failure, hypertension, and major depressive disorder. Interventions included; Floor mat on left side of bed, keep walker in room beside resident as she will permit, If resident refuses to have the blankets taken off of the floor, fold them and keep them beside the chair away from her walking path, Encourage the resident to keep her blankets around her chair off of the floor-resident gets cold and uses multiple blankets to keep warm, Keep phone within reach while in bed, Cue resident during all baths/showers. Remind resident to wait to stand transfer until she has her shoes/gripper socks back on, Resident does transfer and ambulate independently, Gripper socks or appropriate non-skid foot wear at all times, Keep call-light in reach when resident in room. Remind res how and when to use call-light, Remind to ask for assistance.

R20's face sheet, not dated identified current diagnoses of Alzheimer's disease, diabetes, depression with anxiety, osteoarthritis, iron deficiency anemia, chronic kidney disease, and hypertension.

R20's Scene Investigation Report, indicated three falls had occurred in the last month:
1. On 11/3/17, at 2310 (11:10 p.m.)- Resident was found on the floor. Husband came to nurses' station to report resident was on the floor.

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F 689	Continued From page 22 Resident was sitting on floor leaning backwards with blankets under her head. The immediate intervention include gripper socks. The fall team meeting notes dated 11/8/17, indicated the NAR assignment sheet and Profile were updated with these change(s) on 11/8/17 and indicated: "If resident refuses to have blankets taken off of floor, fold them and keep them beside the chair, away form walking path." 2. On 11/24/17, at 1745 (5:45 p.m.)- Resident found sitting on floor next to bed, floor mat in place, bed in low position. Attempted to get self out of bed for supper. No immediate interventions following the fall had been added. The fall team meeting notes dated 11/30/17, revealed no new recommendations. 3. On 11/28/17, at 8 a.m. the resident had been found on bottom in doorway with shoes on. Incident not reviewed by fall committee. On 12/1/17, recommendation for toileting diary was noted. During observation on 11/30/17, at 12:56 p.m. R20 was observed in the dining room, eating lunch independently. During observation on 11/30/17, at 2:03 p.m. R20 was was observed in bed asleep, under the covers, covers off the floor, with floor mat on left side of bed, walker by bed, and call-light in reach. During observation on 12/1/17, at 12:36 p.m. R20's husband was observed to minimally assist R20 from wheelchair to stationary chair in dining room. During interview on 12/1/17, at 10:58 a.m. NA-C stated she does not consistently work on this floor but is familiar with R20. NA-C reported she was	F 689		

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unaware R20 had experienced falls recently, or any fall interventions in place for the resident. NA-C stated R20 fluctuates in the level of assistance she needs with transferring, dressing and toileting, sometimes "not feeling good", confused or mood "may not be good" and needs more help and sometimes is more independent. NA-C reports need to routinely check on R20.

During interview on 12/1/17, at 11:09 a.m. NA-H indicated resident prefers female aides and will ask her husband to help her with things; husband pushes resident to the dining room. NA-H is uncertain but thinks resident dresses self and needs limited assist with toileting. Not aware of resident having falls.

During interview on 12/4/17, at 9:46 a.m. NA-I indicated she consistently works with R20. NA-I reports R20 has had falls recently and has mat on floor, gripper socks, and call-light in reach. NA-J took an ADL sheet out of her pocket , reviewed with NA-I, R20 had no "Fall Management" interventions listed on sheet which was verified by NA-I.

During interview on 12/4/17, at approximately 11 a.m. RN-J indicated she was not sure who was responsible for updating the ADL sheets if changes occurred.

During interview on 12/4/17, at approximately 3 p.m. the DON indicated the nurse mangers on the floors were responsible for updating the ADL sheets.

Policy provided by the facility Fall and injury reduction program dated Review Date: 6/16 indicated, "...Recognition and management of risk

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F 689	Continued From page 24 factors for falling can prevent falls and minimize injuries to enable residents in maintaining maximum mobility and quality of life... Each fall is investigated as soon as possible to determine what the resident was doing when the fall occurred... A plan is then implemented based on the findings of the investigation... All Interventions for fall and injury reduction are noted on the resident's plan of care, care card and/or profile..."	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		1/22/18

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F 758	Continued From page 25 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure Dyskinesia Identification System Condensed User Scale (DISCUS) assessment was completed for 1 of 5 residents (R78) per pharmacist recommendation reviewed for unnecessary medication. Findings Include: R78's face sheet indicated the most recent admission to facility was 7/18/17. R78's face sheet further indicated diagnoses that included: visual hallucination, dementia with Lewy body, weakness and repeated falls. The resident's physician order report dated 5/1/17 through 12/1/17 indicated R78 was on clonazepam 0.5 milligram (mg), Quetiapine 25 mg (an	F 758	F758 It is the policy and expectation of Augustana Health and Rehab of Apple Valley to follow through on recommendations from the consulting Pharmacist. Immediate Corrective Action: AIMS (abmormal movement evaluation) was not completed on R78 due to medication dc□d 11/21/17 Identification of other residents: An audit was conducted of pharmacy recommendations from the past 3 months to ensure that recommendations had been followed through.	

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	245264	A. BUILDING _____ B. WING _____	12/04/2017

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F 758	Continued From page 26 antipsychotic medication), and Quetiapine 12.5 mg as needed every 12 hours. The Minimum Data Set dated 7/25/17, indicated R78 had moderately impaired cognition. The Consultant Pharmacist Communication to Nursing document indicated the pharmacist had made a recommendation on 9/7/17, for an abnormal movement evaluation (AIMS/DISCUS) to monitor for side effects of the antipsychotic medication. During a record review on 12/1/17, there was no evidence of an AIMS/DISCUS evaluation found in R78's medical record. Registered nurse (RN)-J verified during an interview on 12/1/17, at 3:54 p.m. no abnormal movement evaluation had been completed for R78. During an interview on 12/1/17, at 4 p.m. the director of during stated she expected the nurse managers to follow through on all pharmacist recommendations.	F 758	Measures put in place: A tracking system was developed to track pharmacy recommendations when they are received and then when they have been followed up on to ensure that all recommendations are responded to appropriately. Monitoring Mechanisms: Audits will be completed monthly for 2 months of 5 consulting pharmacist recommendations to ensure they have been followed up on appropriately. Results of these audits will be reviewed by the QAPI committee. DON responsible for compliance Date of completion 1/22/18	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals	F 761		1/22/18

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F 761	Continued From page 27 §483.45(h)(1) 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. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure outdated medications were not available for use for 3 residents (R51, R120, R9) during review of 2 of 3 medication carts on the second floor. Findings include: Second floor medication cart #1 was observed on 11/28/17, at 5:04 p.m. with licensed practical nurse (LPN)-A. At that time R51's vial of Humalog insulin was observed to be open, approximately 1/6 full, dated as open 10/24/17, with an expiration of 11/21/17. LPN-A stated nurses were trained to date the insulins when opened and were supposed to keep them in the refrigerator until ready to be used. LPN-A said then they were to be dated when opened, and stored only stored on the medication cart for 28 days after first use. LPN-A further stated R51 took 6 units of the Humalog insulin with meals	F 761	F761 It is the policy and expectation of Augustana Health and Rehab of Apple Valley to ensure that outdated medications are not available for use. Immediate Corrective Action: R51 Humalog insulin was removed from use and disposed of on 11/28/17. R120 Advair was removed from use and disposed of on 11/29/17. R9 Symbicort was removed from use until it could be properly labeled by Pharmacy. Identification of other residents: All medication carts were audited to ensure that medications were dated per policy and that no other expired medications were available for use. Measures put in place:	

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F 761	Continued From page 28 and had no other Humalog insulin on the cart. LPN-A further stated she would dispose of the expired insulin for R51 and would follow their consultant pharmacy (Merwin) guidelines for expiration dates of shortened timeframe medications. R51's physician orders dated 11/1/17-12/1/17, indicated R51 took Humalog insulin 6 units three times a day with meals for Type 2 diabetes mellitus. R51's Medication Administration Record (MAR) dated 11/1/17-12/1/17, indicated R51 was administered Humalog insulin three times daily on 11/22/17 and 11/23/17 (administered 2 days after expiration). The second floor medication cart #3 was observed on 11/29/17, at 1:47 p.m. with LPN-B. During that time an open, unidentified Advair discus was discovered. LPN-B stated she knew the unidentified discus belonged to R120. LPN-B searched the cart and found the label for the Advair and placed the label on the discus identifying R120. LPN-B verified the Advair discus had been opened, but was not dated, with two of 60 doses left. LPN-B stated medication administration staff were trained to date the Advair after opening. LPN-B verified the Merwin pharmacy guideline was that an open Advair disc was good for 30 days after opening the protective foil. LPN-B verified the label indicated pharmacy date of 10/16/17, and stated R120's Advair had expired on 11/15/17. LPN-B stated she would destroy the medication and reorder since it had expired. R120's face sheet printed 12/1/17, indicated R120 had been admitted to the facility on 11/7/17, with a diagnosis of unspecified chronic respiratory	F 761	Licensed staff and TMAs have been re-educated on policy regarding labeling and storage of medications. Monitoring Mechanisms: Audits of 2 facility medication carts will be conducted each week for 3 months to monitor for appropriate labeling and storage of medications. Results of these audits will be reviewed by the QAPI committee. DON Responsible for compliance. Date of completion 1/22/18	

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F 761	Continued From page 29	F 761		

disease. R120's physician orders dated 11/1/17-11/30/17, indicated the Advair discus was to be administered one puff inhalation for shortness of breath two times a day. R120's MAR dated 11/1/7-11/30/17, indicated R120 was administered Advair one time on 11/6/17, after returning from a hospitalization, and zero times on 11/7, 11/8, 11/9 documented as 'Unavailable,' but was administered the Advair twice daily 11/10/17 through 11/30/17 (therefore expired Advair was administered to R120 on 11/16-11/27/17).

During the same observation of medication cart #3 with LPN-B, R9's Symbicort inhaler was observed be open but it was undated, with no label. There were 200 of 204 doses left, and R9's name was handwritten on the inhaler. LPN-B stated she did not know when the inhaler had been opened or when it had been delivered from the pharmacy. LPN-B stated she would send the inhaler back to the pharmacy to be relabeled.

R9's face sheet printed 12/4/17, indicated R9 had been admitted to the facility on 11/10/17, with a diagnosis for chronic obstructive pulmonary disease. R9's physician orders dated 12/4/17, indicated R9 had physician orders for Symbicort 2 puffs inhalation twice a day. R9's MAR dated 11/1/17-11/30/17, indicated R9 was administered Symbicort 26 times in November.

On 12/1/17, at 11:14 a.m. director of nursing (DON) stated staff should date shortened time frame medications when opening and stated every time staff where looking in the medication cart they should be looking for, and pulling, any medications that had expired and reorder.

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F 761	Continued From page 30 On 12/1/17, at 1:23 p.m. the DON verified R51's MAR indicated R51 was administered Humalog insulin on 11/22/17 and 11/23/17, past the use by date. The DON stated staff were trained to follow the medication storage and expiration guidelines provided by the consultant pharmacy (Merwin) guide sheet dated 8/2015. The DON also stated when medications with shortened time frames for effectiveness were opened and undated, staff were to look at the date the medication came up from pharmacy and use that date as opened; and were to call the pharmacy if needed. The facility's Medication Storage policy dated 4/2016, indicated, " ... 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed... 12. Refer to Storage and expiration guidelines from pharmacy for specific details regarding storage for particular medications." Merwin Medication Storage and Expiration Guidelines indicated the Advair Discus expired 30 days after opening, and to date when opened, Insulin expired 28 days after 1st use and to date when open, and Latanoprost eye drops expired 42 days after 1st use and to date when open. The same Merwin guidelines also indicated, "... Specified medications found undated when opened will be presumed to have been opened as of the date of dispensing ..."	F 761		

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	245264	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/29/2017**

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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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey dated November 29, 2017, the Augustana Health Care Center of Apple Valley was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 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 (K TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/22/2017

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

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K 000	Continued From page 1 Or by email to: Marian.Whitney@state.mn.us or 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 Apple Valley is a 3-story building with a full basement. The building was constructed in 1983, and was determined to be of Type II(222) construction. The building has an automatic sprinkler system installed throughout in accordance with NFPA 13 Standard for Installation of Automatic Sprinkler Systems (2010 edition). The facility has a fire alarm system with smoke detection throughout the corridor system and in the common spaces. The fire alarm system is monitored for automatic fire department notification and is installed in accordance with NFPA 72 "The National Fire Alarm Code" (2010 edition). Hazardous areas have automatic fire detection that is on the fire alarm system in accordance with the Minnesota State Fire Code (2015 edition).	K 000		

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K 000	Continued From page 2 The facility has a capacity of 178 beds and had a census of 158 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 374 SS=C	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility has failed to maintain 1 of 5 smoke/fire barrier doors in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.3.7.4. This deficient practice could affect 32 of 178 residents as well as an undetermined number of staff, and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include:	K 374	K374 Correction Door Did Not Close Barrier door top latch did not engage, in order to correct this deficiency maintenance inspected all doors to make certain it was not a systemic concern. We found out the door in question needed lubrication to allow the latch to release in order to engage and lock. Door was adjusted and currently works as intended. All barrier doors will be tested monthly during required fire drills.	1/22/18

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K 374	Continued From page 3 On facility tour between 9:00 a.m. to 2:00 p.m. on 11/29/2017, observation revealed that the 1 of the 2 smoke barrier double doors located on the second floor do not latch and close properly. This deficient practice was confirmed by the Maintenance Supervisor.	K 374		
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the	K 920	K920 Power Cords Improper Usage	1/22/18

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K 920	Continued From page 4 facility failed to ensure a multiple outlet connection was in accordance with the 2012 edition of NFPA 99 section 10.2.3.6 item 2 for total ampacity. This deficient practice could cause an overload of a circuit which could cause a power outage to necessary equipment or cause a fire. This could affect an undetermined amount of staff and visitors. Findings include: On the facility tour between 09:00 AM to 2:00 PM on 11/29/2017, observations and staff interview revealed: 1) Rm 223 Refrigerator was plugged into an unapproved multi-plug adapter. 2) Rm 251 and 327 had a refrigerator plugged into a power strip. This deficient practice was confirmed by the Maintenance Supervisor.	K 920	Augustana maintenance team did a whole house inspection and removed all power strips within the building. Augustana will no longer supply or stock power strips for use within the building. Our policy will now prohibit all power strips and cords to be used within facility. We have started a plan to have outlets installed in rooms where the need for more plugin locations are required. Our standard going forward will be a power strip free building.	