DEPARTMENT OF HEALT			D CERTIFIC	CATION A	CENTERS FOR MEI AND TRANSMITTAL	DICARE & MEDICAID SERVICES ID: XYMH
	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00144
1. MEDICARE/MEDICAID PROVID NO.(L1) 245187	DER	3. NAME AND AI (L3) TEXAS TER	RRACE CARE	E CENTER	1	4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification
2. STATE VENDOR OR MEDICAIE (L2) 276542000	D NO.	(L4) 7900 WEST (L5) SAINT LOU			(L6) 55426	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF (L9) 07/01/2015	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEG 05 HHA	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 12/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	14/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
11LTC PERIOD OF CERTIFICATIO From (a): To (b):	Ν	Compliance	ance With equirements e Based On:	AS:	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds 13.Total Certified Beds	118(L18)118(L17)	B. Not in Comp	cceptable POC bliance with Progr and/or Applied V		4. 7-Day RN (Rural SN 5. Life Safety Code * Code: A	 4F)8. Patient Room Size 9. Beds/Room (L12)
14. LTC CERTIFIED BED BREAKDO	OWN	requirements	and/or reppiled	vuivers.	15. FACILITY MEETS	(112)
18 SNF 18/19 SNF 118	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM 17. SURVEYOR SIGNATURE Corrige Eucode, HEEL		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Carrie Euerle, HFE I		1	/24/2017	(L19)	Kamala Fiske-Downing,	Enforcement Specialist 01/27/2017 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	COFFICE OR SINGLE S	TATE AGENCY
 DETERMINATION OF ELIGIBII 1. Facility is Eligible to 1 2. Facility is not Eligible 	Participate		IPLIANCE WITH HTS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) > :
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	(L30)
OF PARTICIPATION 02/01/1978	BEGINNINC	6 DATE	ENDING DA	TE	VOLUNTARY 00 01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	
25. LTC EXTENSION DATE:	27. ALTERNATT A. Suspension	VE SANCTIONS n of Admissions:	(L44)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	on <u>OTHER</u> 07-Provider Status Change 00-Active
(L27)	B. Rescind Su	spension Date:	(L11)			
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS	
		06301				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	N OF APPROVAL	L DATE		
	(L32)			(L33)	DETERMINATION APP	ROVAL



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Revised Letter with Revised Sent Date

CMS Certification Number (CCN): 245187

January 3, 2016

Mr. Reid Hewitt, Administrator Texas Terrace Care Center 7900 West 28th Street Saint Louis Park, MN 55426

Dear Mr. Hewitt:

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 November 30, 2016 the above facility is certified for:

118 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 118 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,

Texas Terrace Care Center January 3, 2016 Page 2

Kumalu Fiske Downing

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



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered January 24, 2017

Mr. Reid Hewitt, Administrator Texas Terrace Care Center 7900 West 28th Street Saint Louis Park, MN 55426

RE: Project Number S5187025

Dear Mr. Hewitt:

On September 23, 2016, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective September 28, 2016. (42 CFR 488.422)

On November 22, 2016, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Per instance civil money penalty of \$3,263 for the deficiency cited at F226 (S/S: F) (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 2, 2016. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of November 22, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 2, 2016.

This was based on the deficiencies cited by this Department for an extended survey completed on September 2, 2016. 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) whereby corrections are required.

On October 27, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on September 2, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 12, 2016. Based on our visit, we determined that your facility had not corrected the deficiencies issued

Texas Terrace Care Center January 24, 2017 Page 2

pursuant to the extended survey, completed on September 2, 2016. As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

On December 14, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on December 14, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 30, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on December 14, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective November 30, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of :

- Per instance civil money penalty will remain in effect. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective December
- 2, 2016, be rescinded effective November 30, 2016. (42 CFR 488.417 (b))

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.

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,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u> Texas Terrace Care Center January 24, 2017 Page 3

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION		C	DATE OF REVIS	IT
IDENTIFICATION NUMBER	A. Building				
245187 _{Y1}	B. Wing	Y2	2 1	2/14/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
TEXAS TERRACE CARE CEN	TER	7900 WEST 28TH STREET			
		SAINT LOUIS PARK, MN 55426			

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

ITEM	DATE	ITEM	DATE	ITEM		DATE
Y4	Y5	Y4	Y5	Y4		Y5
ID Prefix F0282 483.20(k)(3)(ii) Reg. #	Correction Completed	ID Prefix F03 483.7 Reg. #			F0323 483.25(h)	Correction
LSC	11/30/2016		11/30/2			11/30/2016
ID Prefix	Correction	ID Prefix	Correc	tion ID Prefix		Correction
Reg. # 	Completed	Reg. # 	Compl	eted Reg. # LSC		Completed
ID Prefix	Correction	ID Prefix	Correc	tion ID Prefix		Correction
Reg. #	Completed	Reg. #	Compl	eted Reg. #		Completed
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Correc	tion ID Prefix		Correction
Reg. #	Completed	Reg. #	Compl	eted Reg. #		Completed
LSC				LSC		-
ID Prefix	Correction	ID Prefix	Correc	tion ID Prefix		Correction
Reg. #	Completed	Reg. #	Compl	eted Reg. #		Completed
LSC		LSC		LSC		-
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS) GD/kfd	DATE 1/24/2017	SIGNATURE OF SURVEY	OR 3159 ²	DATE	/14/2016
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE	5139	DATE	11712010
FOLLOWUP TO SURVEY 9/2/2016	COMPLETED ON		OR ANY UNCORRECTED DE ECTED DEFICIENCIES (CMS			es 🔲 no



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

January 24, 2017

Mr. Reid Hewitt, Administrator Texas Terrace Care Center 7900 West 28th Street Saint Louis Park, MN 55426

Re: Project Number S5187025

Dear Mr. Hewitt:

On December 14, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 14, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kumala Fiske Downing

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

cc: Licensing and Certification File

STATE FORM: REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building			DATE OF REVI	SIT
	5			1	
00144 _{Y1}	B. Wing	Y	Y2	12/14/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
TEXAS TERRACE CARE CEN	TER	7900 WEST 28TH STREET			
		SAINT LOUIS PARK, MN 55426			

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

ITE	Μ	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix	20565	Correction	ID Prefix	20830	Correction	ID Prefix	20900	Correction
Reg. #	MN Rule 4658.0 Subp. 3	Completed		MN Rule 4658.0520 Subp. 1	Completed	Reg. #	MN Rule 4658.05 Subp. 3	25 Completed
LSC		11/30/2016	LSC _		11/30/2016	LSC		11/30/2016
ID Prefix		Correction	ID Prefix _		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC		-	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC		-	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC		-	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC		-	LSC		
REVIEW		REVIEWED BY	DATE	SIGNATURE OF	SURVEYOR	-		DATE
		REVIEWED BY (INITIALS) GD/kfd	1/24/201			31591		12/14/2016
REVIEW		REVIEWED BY (INITIALS)	DATE	TITLE				DATE
FOLLOW 9/2/2016		COMPLETED ON		K FOR ANY UNCORRE				YES 🗌 NO

DEPARTMENT OF HEAI	MEDICA	ARE/MEDICAL			ND TRANSMITTAL	DICARE & MEDICAID SERVICES ID: XYMH Facility ID: 00144
MEDICARE/MEDICAID PROV NO.(L1) 245187 STATE VENDOR OR MEDICA (L2) 276542000		 NAME AND AI (L3) TEXAS TEH (L4) 7900 WEST (L5) SAINT LOU 	RRACE CARE 28TH STREE	CENTER T	(L6) 55426	4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE C (L9) 07/01/2015 6. DATE OF SURVEY 1(8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Othe)/27/2016 ^{L34)} (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	JPPLIER CATEG 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	ORY 09 ESRD 10 NF 11 ICF/IID 12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 12/31
 11LTC PERIOD OF CERTIFICAT From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	118 (L18) 118 (L17)	Compliance 1. A B. Not in Comp	ance With equirements e Based On: cceptable POC	am	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SI 5. Life Safety Code * Code: B	7. Medical Director
14. LTC CERTIFIED BED BREAK 18 SNF 18/19 SN 118 (L37) (L38)		ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
 STATE SURVEY AGENCY RE SURVEYOR SIGNATURE Amy Charais, HFE 	· · ·	Date :	2/6/2016	DATE):	18. STATE SURVEY AGENCY	
•				(L19)	OFFICE OR SINGLE S	, Enforcement Specialist 12/15/2016 (L20)
 DETERMINATION OF ELIGII 1. Facility is Eligible t 2. Facility is not Eligit 	o Participate		IPLIANCE WITH HTS ACT:	I CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :
22. ORIGINAL DATE OF PARTICIPATION 02/01/1978 (L24)	23. LTC AGREEN BEGINNINC (L41)		 LTC AGREEM ENDING DAT (L25) 		26. TERMINATION ACTION <u>VOLUNTARY</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimburs	0 INVOLUNTARY 05-Fail to Meet Health/Safety
25. LTC EXTENSION DATE: (L27)	-	VE SANCTIONS a of Admissions: aspension Date:	(L44)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHER
28. TERMINATION DATE:	(L28)	. INTERMEDIARY/ 06301	(L45) /CARRIER NO.	(L31)	30. REMARKS	
31. RO RECEIPT OF CMS-1539	32 (L32)	. DETERMINATION	I OF APPROVAL	DATE (L33)	DETERMINATION APP	ROVAL



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

November 14, 2016

Mr. Reid Hewitt, Administrator Texas Terrace Care Center 7900 West 28th Street Saint Louis Park, MN 55426

RE: Project Number S5187025

Dear Mr. Hewitt:

On September 23, 2016, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective September 28, 2016. (42 CFR 488.422)

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their Letter of September 23, 2016.

• Per instance civil money penalty for the deficiency cited at F226. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an extended survey completed on September 2, 2016. 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) whereby corrections are required.

On October 27, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on September 2, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 12, 2016. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our standard extended survey, completed on September 2, 2016. As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan F0323 -- S/S: D -- 483.25(h) -- Free Of Accident Hazards/supervision/devices

In addition, at the time of this revisit, we identified the following deficiency:

Texas Terrace Care Center November 14, 2016 Page 2

F0314 -- S/S: D -- 483.25(c) -- Treatment/Svcs To Prevent/heal Pressure Sores

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

Based on the findings of this visit, we recommended to the CMS Region V Office the following additional remedy:

• Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

Compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the September 2, 2016 extended survey has not yet been verified.

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.

As we notified you in our letter of September 23, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 2, 2016.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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 electronic plan of correction should be directed to:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Texas Terrace Care Center November 14, 2016 Page 3

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

Texas Terrace Care Center November 14, 2016 Page 4

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 PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 2, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal

Texas Terrace Care Center November 14, 2016 Page 5 dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			1		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		0	MB NO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	СОМ	E SURVEY PLETED
		245187	B. WING				੨ 27/2016
NAME OF F	PROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE		
ΤΕΥΔΟΤ	ERRACE CARE CEN	TER		7	7900 WEST 28TH STREET		
ILAASI		i En		9	SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENT	ſS	{F 00	00}			
	of this department of to determine compl deficiencies issued exited on 9/2/16. Duregulations were de In addition, a new of Also there are tag/s at the time of onsite the CMS2567. The corrected can be for Because you are en- signature is not req page of the CMS-2: submission of the F verification of comp Upon receipt of an on-site revisit of you validate that substa- regulations has bee your verification. You have agreed to receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a Department of Hea you electronically. is necessary for Sta- enter the word "cor- text. You must then	during a recertification survey uring this visit the following etermined to be not corrected. ertification tag was written. a that were not found corrected e PCR which are located on certification tags that were und on the CMS2567B. nrolled in ePOC, your uired at the bottom of the first 567 form. Your electronic POC will be used as bliance. acceptable electronic POC, an ur facility will be conducted to untial compliance with the en attained in accordance with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are					
LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

Electronically Signed

11/22/2016

PRINTED: 12/07/2016

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.

		AND HUMAN SERVICES				FORM	APPROVED
	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIP	LE CONSTRUCTION		0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245187	B. WING				R 27/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS	FERRACE CARE CEN	TER			7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 000}	completion date, the corrected prior to el Minnesota Departm On 9/2/16, surveyor visited the above pr correction orders ar your electronic plan reviewed these ordet they will be complet Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag n column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement, evidence by." Follow are the Suggested Time period for Cor PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA	e date your orders will be lectronically submitting to the nent of Health. rs of this Department's staff, rovider and the following re issued. Please indicate in of correction that you have ers, and identify the date when ted. nent of Health is documenting Correction Orders using ag numbers have been tota state statutes/rules for umber appears in the far left Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the his column also includes the n violation of the state statute "This Rule is not met as wing the surveyors findings Method of Correction and rection. RD THE HEADING OF THE	{F 0(00}			

Facility ID: 00144

If continuation sheet Page 2 of 13

		AND HUMAN SERVICES			FOR	D: 12/07/2016 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DA	NTE SURVEY
		245187	B. WING	i	10	R D/ 27/2016
NAME OF F	PROVIDER OR SUPPLIER		<u>.</u>		TREET ADDRESS, CITY, STATE, ZIP CODE	
TEXAS T	ERRACE CARE CEN	TER			900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 282} {F 282} SS=D	PERSONS/PER CA The services provided b accordance with ea care. This REQUIREMEN by: Based on observat review, the facility fa planned intervention reviewed who had s facility. findings include: R148's significant of (MDS), dated 10/7/ cognitively impaired bladder, and required grooming, toileting, Care Area Assessm indicated R148 was history of falls, bala medication use and care plan for interved dated 10/13/16, ide facility and included Auto locking brakes from rolling backwa and orthostatic bloc	AVICES BY QUALIFIED ARE PLAN led or arranged by the facility y qualified persons in icch resident's written plan of NT is not met as evidenced tion, interview and document ailed to implement care ns for 1 of 3 residents (R148) sustained multiple falls in the change Minimum Data Set 16, indicated he was severely d, incontinent of bowel and ed assistance with dressing, transfers and bed mobility. A nent (CAA) dated 10/7/16, a trisk for falls related to a nce impairment and d directed staff to refer to his entions. R148's care plan ntified a history of falls in the d the following interventions: a to prevent the wheel chair ards upon standing, grab bars, od pressures weekly.	{F 2 {F 2		Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with the facts and conclusion in the statement of deficiencies. This Plan of Correction is prepared and executed a a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and it constitutes the facility's allegation of compliance. 1. Resident #148 fall care plan was reviewed and fall interventions have beer implemented as care planned. 2. Resdient with falls within the last 30 days care plans have been reviewed to assure that fall interventions are implemented as ordered and recommended. 3. Staff have been educated regarding th implementation and use of fall interventions as ordered/recomended. 4. Director of Nursing/designee will audit	n s e
	Notes dated 9/2/16	errace Care Center Progress through 10/26/16 indicated ore than twelve falls without since 9/2/16.			residents with falls per week for one month to assure fall interventions are car planned and in place. Continued audits o 5 residents per month will continue unit	

Facility ID: 00144

If continuation sheet Page 3 of 13

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
			A. BOILDI	<u>.</u>		F	R
		245187	B. WING _				27/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	TER			900 WEST 28TH STREET		
				S	AINT LOUIS PARK, MN 55426		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL	ID PREFIX	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPP DEFICIENCY)	RIATE	DATE
			ı		DEHOLENOTY		
{F 282}	Continued From pa	ae 3	{F 28	21			
(· _•_j	Continued i rom pa	geo	11 20	ر ک ر	dsicontinued by QAPI committee.		
	During an observati	ion on 10/27/16, at 8:06 a.m.,					
		elling on the unit. He was in a					
		ir with no auto locking brakes ation of R148's room identified					
	grab were not place						
	•						
		Terrace Medication					
		ord dated October 2016 c blood pressures were to be					
		or R148 however, on both					
		16, the blood pressures were					
		le R148 was lying down and ing blood pressures were					
		7/16 and 10/24/16, there was					
	no evidence of any						
		on 10/26/16, at 11:40 a.m., urse (LPN)-C stated after a					
		irse on the floor completed an					
	incident report and	the interdisciplinary team					
		fall. She stated during one of					
		as determined that auto Id be implemented to prevent					
		olling backwards when he					
		ed the auto-locking brakes					
		ed to R148's wheel chair. ed the orthostatic blood					
		been completed as directed in					
	the care plan.						
	During on interview	$an \frac{10}{96} \frac{10}{16} = \frac{11}{10} \frac{10}{10} = \frac{10}{10} \frac{10}{10} \frac{10}{10} = \frac{10}{10} \frac{10}{10} = \frac{10}{10} \frac{10}{10} \frac{10}{10} \frac{10}{10} = \frac{10}{10} \frac{10}{10} \frac{10}{10} \frac{10}{10} = \frac{10}{10} 1$					
		on 10/26/16, at 1:49 p.m., the DON) stated R148 should					
		placed on his bed. In regard					
	to the orthostatic blo	ood pressures, the DON					
		have been changed to monthly					
		but stated they should have hey were on the medication					
	administration shee						

If continuation sheet Page 4 of 13

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		BERTH IO/TION NOWBER.	A. BUILDIN	G		3
		245187	B. WING		10/2	27/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	TER		7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 282}	Continued From pa	ge 4	{F 282	}		
	registered nurse co have had auto locki chair. She stated th stock and they had day,15 days after th the care plan.	on 10/26/16, at 1:49 p.m., the nsultant stated R148 should ng brakes applied to his wheel e facility did not have them in been ordered the previous he intervention was listed on				
F 314 SS=D	Assessment and M July 2015 was revie to implement a fall/i resident's needs an needed to reduce th		F 314	4		11/30/16
	resident, the facility who enters the facil does not develop pr individual's clinical of they were unavoida pressure sores rece	rehensive assessment of a must ensure that a resident ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and a healing, prevent infection and from developing.				
	by: Based on observat review the facility fa assess and identify residents (R106), re	NT is not met as evidenced ion, interview and document iled to comprehensively pressure ulcers for 1 of 3 eviewed for nutritional risk but e ulcers in the facility.		1. Resident #106 was evaluated by wound MD and area of deviation wa diagnosed as moisture related derm Resident care plan has been review and updated as indicated, including treatment of moisture barrier as ord NAR A and NAR B have recieved	as natitis. ved	

Facility ID: 00144

If continuation sheet Page 5 of 13

STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION	1	<u>. 0938-039</u> E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		IG		IPLETED
		045107				R
		245187	B. WING _	STREET ADDRESS, CITY, STATE, ZIF		27/2016
NAME OF	PROVIDER OR SUPPLIER			7900 WEST 28TH STREET	CODE	
TEXAS		TER		SAINT LOUIS PARK, MN 5542	26	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 314	Continued From pa	ae 5	F 31	4		
	R106's quarterly Mi 10/16/16, indicated cognitive impairment bowel and bladder, bed mobility, transfe pressure ulcers but pressure ulcers but pressure ulcer. R106's Care Area A 1/22/16, indicated F assist of one for toi brief, required assis skin breakdown and ulcer "resolved" 1/4 care plan should sle complications and n On 10/25/16, at 2:3 sitting in his wheeld water out of a two h he had been eating On 10/27/16, at 7:5 sitting in his wheeld water out of a two h he had been eating On 10/27/16, at 7:5 sitting in his wheeld R106 waved at sum stated "my bottom h staff person]?." "[Ac identified as the act the floor. The conve time to A and licens who stated R106 "c ulcer." On 10/27/16 at 8:44 still be in dining roo	inimum Data Set (MDS) dated the resident had severe nt, was always incontinent of required extensive assist with ers and was at risk for a did not currently have a Assessment (CAA) dated R106 was incontinent of bowel, leting, required an incontinent st with bed mobility, at risk for d had a stage four pressure 1/16. The CAA indicated the ow or minimize decline, avoid minimize risks. 88 p.m., R106 was observed chair in his room. 51 a.m., R106 was observed chair in the dayroom drinking nandled lid cup. R106 stated		 education related to notific changes in resident status Resident skin sweep ha completed throughout the skin checks are being cor LN's and NAR's have b regarding skin policies, indidentification of skin changes skin changes and docume changes. Director of Nursing/des residents per week with hi alteration for one month to protocols are in place incliskin assessment complete audits of 5 resident per m completed monthly until d QAPI. 	5. as been facility. Weekly npleted by LN. een educated cluidng the ges, reporting of entation of skin ignee will audit 5 igh risk for skin o ensure skin uding weekly ed. Continued onth will be	

If continuation sheet Page 6 of 13

		AND HUMAN SERVICES				FORM	: 12/07/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DAT CON	E SURVEY
		245187	B. WING	i			R / 27/2016
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
TEXAS	ERRACE CARE CEN	TER			7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	LPN-C who stated ' [nursing aide] this m was anything wrong breakfast." On 10/27/16, at 9:3 and stated "I'm bett grab bar but was un LPN-C used grab li A Stage II pressure loss involving epide ulcer is superficial a abrasion, blister, or was observed to be centimeter (cm) wit tissue. Barrier creat LPN-C stated "yes, LPN-C stated she w ulcer, "no one has t R106's care plan da weekly skin assess Risk Assessment (I pressure ulcers) of risk of developing p issues since last re transfers. The care sheet to move resid turning if area of re avoid positioning or pressure reduction chair and bed and a Review of two EHS dated 10/14/16, ind areas of impairment Review of a Brader dated 10/14/16, ind	"I repositioned him and the NA norning did not tell me there g. I will check his bottom after 9 a.m. R106 was laying in bed her now." R106 reached for nable to reposition himself. ft sheet to roll him to his side. ulcer (partial thickness skin ermis, dermis, or both. The and presents clinically as an shallow crater) on the coccyx e approximately 2.0 X .5 h non-blanchable surrounding m was on the coccyx area. that's greasy." At 9:42 a.m. vas not aware of the pressure cold me." ated 10/14/16, indicated the ment was reviewed, Braden evel of risk for development of 17 on 8/8/16 indicating a mild pressure ulcer, no skin/wound view and was one assist for plan directed staff to use lift dent, increase frequency of dness is non-blanchable, n trochanter (thigh bone), or pressure relief surface for apply topical skin protectant. I Skin Assessments, both icated there were no "no	F	314			

If continuation sheet Page 7 of 13

	-	AND HUMAN SERVICES & MEDICAID SERVICES					FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	E CONSTRUCTION		(X3) DATE	E SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG				PLETED
		245187	B. WING _					੨ 2 7/2016
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP COD	Ε		
TEXAS T	ERRACE CARE CEN	TER			900 WEST 28TH STREET			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	-	PROVIDER'S PLAN OF CORRI		N	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD	BE	COMPLETION DATE
F 314	Continued From pa	ge 7	F 3	14				
	sheet last updated assist of one for tra	ng aide 2nd Floor Team 5 care 8/31/16, indicated R106 was nsfers and bed mobility and nd repositioned every two						
	indicated to conduc							
		n order dated 10/10/16, ster 120 milliliter house day.						
	September 2016, ir ordered weekly skin Three of four physic checks for October Allevyn dressing to other day] and prn (ment Order Sheets for ndicated two of five physician n checks were not completed. cian ordered weekly skin 2016 were not completed. coccyx, "change QOD [every (as needed), cleanse with NS s added on 10/27/16.						
	nursing aide (NA)-A a little red yesterday and today she put b because the "bottor yesterday. NA-A sta and normally he do the chair, so "I laid R106 needed assis was "check and cha	с с						
		on 10/27/16, at 11:44 a.m. tom started to hurt "quite						

Facility ID: 00144

If continuation sheet Page 8 of 13

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 12/07/2016 APPROVED . 0938-0391
STATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		PLE CONSTRUCTION	(X3) DAT CON	TE SURVEY MPLETED
		245187	B. WING	à			R / 27/2016
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
TEXAS	FERRACE CARE CEN	TER			7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 314	awhile ago", but wa ago that was. R106 the room stated he awhile ago." S-A sta to lay him down bee wheelchair from aft was unable to clarif During interview on LPN-C stated R106 areas on his coccyp but doesn't like to la got the tilt wheelcha LPN-C stated R106 9/2/16, and has not although he had an on his IT, "he could was not aware until and would have exp "even if it was just r During interview on administrator stated had cared for R106 pm shifts and night cared for R106 on shifts. R106 was gin noticed some redne because it was clos cream in the room, every time R106 wa report this to anyon night shift he notice with soap and wate and did not tell the should have been r four different oppor	s unable to state how long 's spouse (S)-A who shares had an "abscess before, quite ated she was "after" the aides cause he was sitting in his er lunch until the pm shift. S-A y when the incident happened. 10/27/16, at 12:55 p.m. has had "on and off open and ischial tuberosity (IT)" ay down", so that is when they air so he could lay back. has had no wounds since had any for many months, abscess many months ago hardly sit." LPN-C stated she now about the pressure ulcer bected the aides to tell her,	F	314			

Facility ID: 00144

If continuation sheet Page 9 of 13

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES				VB NO. 0938-0391 (X3) DATE SURVEY	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	``'		E CONSTRUCTION	(-)	E SURVEY IPLETED
			_				R
		245187	B. WING			10/27/2016	
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	TER			00 WEST 28TH STREET AINT LOUIS PARK, MN 55426		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTI		(X5)
PRÉFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO		COMPLETION DATE
					DEFICIENCY)		
F 314	Continued From pa	ao 0	F 3				
1 014		x to nursing since 10/25/16.	гэ	14			
		y Wound Prevention and					
		re dated July 2015 indicated s all residents as at risk for					
	skin impairment and	d will implement the following					
		vent the development of duce occurrence of pressure					
		nce to minimize injury, protect					
	against the adverse						
		(pressure, friction, shear) and ness of pressure ulcer					
	prevention through	educational programs." The					
		sment procedure dated July facility requires staff to					
		skin assessment which					
	includes a head to t	toe visualization of the					
		umenting any impairment, on, type and size, and the need					
	to monitor until hea						
	A wound according	nt completed by LPN-C on					
		ested but not provided.					
{F 323}	483.25(h) FREE OF	ACCIDENT	{F 32	23}			11/30/16
SS=D	HAZARDS/SUPER	VISION/DEVICES					
		sure that the resident					
		ns as free of accident hazards					
		each resident receives on and assistance devices to					
	prevent accidents.						
		JT is not mat as a defense d					
	This REQUIREMEN	NT is not met as evidenced					
		ion, interview and document			1. Resident #148 fall care plan w	as	

Facility ID: 00144

If continuation sheet Page 10 of 13

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
		245187	B. WING			₹ 2 7/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10/4	27/2010
	ERRACE CARE CEN	TER		7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
{F 323}	for accidents who s facility. findings include: R148's significant c (MDS), dated 10/7/ cognitively impaired bladder, and required grooming, toileting, Care Area Assessm indicated R148 was history of falls, bala medication use and care plan for interve A review of Texas T Notes dated 9/2/16 R148 sustained mo injury in the facility s A facility document Occurrence dated 9 sustained a fall atte A Texas Terrace Oc indicated R148 fell his wheel chair. A T dated 9/14/16, indic transfer from his wh Terrace Occurrence another fall reported unwitnessed by stat Occurrence dated 9 found lying next to F untitled document of fell again while atter	ailed to implement of 3 residents (R148) reviewed ustained multiple falls in the hange Minimum Data Set 16, indicated he was severely d, incontinent of bowel and ed assistance with dressing, transfers and bed mobility. A nent (CAA) dated 10/7/16, a trisk for falls related to a nce impairment and directed staff to refer to his entions. Ferrace Care Center Progress through 10/26/16, indicated re than twelve falls without since 9/2/16. titled Texas Terrace 0/2/16, indicated R148 mpting to get to the bathroom. courrence dated 9/5/16, attempting to self transfer into exas Terrace Occurrence eated he fell attempting to neel chair to his bed. A Texas e dated 9/27/16, indicated d by the resident but	{F 323	 reviewed and fall interventions has implemented as care planned. 2. Residents with falls within the I days care plans have been review assure that fall interventions are implemented as ordered and recommended. 3. Staff have been educated regating implmentation and use of fall interventions ordered/recommended. 4. Director of Nursing/designee was residents with falls per week for comonth to assure fall interventions planned and in place. Continued residents per month will continue discontinued by QAPI. 	ast 30 ved to rrding the rventions vill audit 5 one are care audit of 5	

If continuation sheet Page 11 of 13

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	12/07/2016 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245187	B. WING				R 27/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TEYAS	TERRACE CARE CEN	TER		79	900 WEST 28TH STREET		
TEXAO				S	SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 323}	indicated he fell aga chair to his bed. A T dated 10/9/16, indic his bathroom 2 day Occurrence dated 1 while attempting to On 10/17/16, a Texa indicated he was fo a housekeeper. And Occurrence dated 1 attempting to transf Texas Terrace Occu found on the floor b A review of R148's identified a history of included the followin brakes to prevent th backwards upon sta orthostatic blood pr During an observati R148 was self prop standard wheel chai in place. An observ no grab bars were i A review of a Texas Administration Reco indicated orthostatic completed weekly f 10/3/16 and 10/10/- only completed whii sitting up. No stand completed. On 10/1 no evidence of any	ain transferring from his wheel Texas Terrace Occurrence cated he self reported a fall in <i>y</i> s prior. A Texas Terrace 10/10/16, indicated R148 fell self transfer to the bathroom. tas Terrace Occurrence bund on the floor in his room by other Texas Terrace 10/17/16 indicated he fell again fer to the toilet. On 10/20/16, a urrence indicated he was beside his bed. care plan dated 10/13/16, of falls in the facility and ing interventions: Auto locking he wheel chair from rolling anding, grab bars, and ressures weekly. tion on 10/27/16, at 8:06 a.m., belling on the unit. He was in a air with no auto locking brakes vation of R148;s room identified in place on his bed. s Terrace Medication for R148 however, on both 16, the blood pressures were ile R148 was lying down and ding blood pressures were 17/16 and 10/24/16, there was	{F 3:	23}			

If continuation sheet Page 12 of 13

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM): 12/07/2016 APPROVED). 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT CON	TE SURVEY MPLETED
		245187	B. WING	·			R / 27/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
TEXAS 1	ERRACE CARE CEN	TER			900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
{F 323}	incident report and (IDT) reviews each the IDT reviews it w locking brakes wou R148's chair from r stood. LPN-C verifie had not been applie LPN-C further verifie pressures had not be the care plan. During an interview director of nursing (have had grab bars to the orthostatic bl stated they should l instead of weekly, be been completed if t administration shee During an interview registered nurse co have had auto lock chair. She stated the stock and they had day,15 days after th the care plan. A facility policy titled Injuries Program, d The policy indicated the risk for falls and implementation of t provide an environr	urse on the floor completed an the interdisciplinary team fall. She stated during one of vas determined that auto ald be implemented to prevent rolling backwards when he ed the auto-locking brakes ed to R148's wheel chair. ied the orthostatic blood been completed as directed in on 10/26/16, at 1:49 p.m., the (DON) stated R148 should s placed on his bed. In regard lood pressures, the DON have been changed to monthly but stated they should have they were on the medication	{F 3	23}			

Facility ID: 00144

If continuation sheet Page 13 of 13

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building		DA	ATE OF REVIS	IT
	B. Wing	Y2	2 10	0/27/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
TEXAS TERRACE CARE CEN	TER	7900 WEST 28TH STREET			
		SAINT LOUIS PARK, MN 55426			

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

ITE			DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	F0225		Correction	ID Prefix	F0226		Correction	ID Prefix	F0254		Correction
Reg. #	483.13(c)(1)(ii)- - (4)	(iii), (c)(2)	Completed	Reg. #	483.13	(c)	Completed	Reg. #	483.15(h)(3)		Completed
LSC			10/16/2016	LSC			10/16/2016	LSC			10/16/2016
ID Prefix	F0279		Correction	ID Prefix	F0280		Correction	ID Prefix	F0309		Correction
Reg. #	483.20(d), 483.2	20(k)(1)	Completed	Reg. #	483.20 (2)	(d)(3), 483.10(k)	Completed	Reg. #	483.25		Completed
LSC			10/16/2016	LSC			10/16/2016	LSC			10/16/2016
ID Prefix	F0325		Correction	ID Prefix	F0329		Correction	ID Prefix	F0334		Correction
Reg. #	483.25(i)		Completed	Reg. #	483.25	(1)	Completed	Reg. #	483.25(n)		Completed
LSC			10/16/2016	LSC			10/16/2016	LSC			10/16/2016
ID Prefix	F0356		Correction	ID Prefix	F0441		Correction	ID Prefix	F0496		Correction
Reg. #	483.30(e)		Completed	Reg. #	483.65		Completed	Reg. #	483.75(e)(5)-(7)		Completed
LSC			10/16/2016	LSC			10/16/2016	LSC			10/16/2016
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	483.75(m)(2)		Completed	Reg. #	483.75	(0)(1)	Completed	Reg. #			Completed
LSC			10/16/2016	LSC			10/16/2016	LSC			
REVIEW		REVIEW (INITIAL		DATE 11/14/2	016	SIGNATURE OF	SURVEYOR	35569		DATE 10	/27/2016
REVIEWI CMS RO		REVIEW (INITIAL	ED BY	DATE		TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 9/2/2016					R ANY UNCORREC					s 🗌 no	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered November 15, 2016

Mr. Reid Hewitt, Administrator Texas Terrace Care Center 7900 West 28th Street Saint Louis Park, MN 55426

RE: Project Number F5187025

Dear Mr. Hewitt:

On November 14, 2016, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on November 14, 2016. We presumed, based on your plan of correction, that your facility had corrected the life safety code deficiencies. Based on our LSC PCR, we have determined that your facility has corrected the life safety code deficiencies issued pursuant to our survey, completed on November 14, 2016.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B for life safety code only) from this visit.

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,

Kumala Piske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us Texas Terrace Care Center November 15, 2016 Page 2

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01		DATE OF REV	ISIT
	B. Wing	Y2	11/14/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS TERRACE CARE CEN	TER	7900 WEST 28TH STREET		
		SAINT LOUIS PARK, MN 55426		

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

ITEI	М	DATE	ITEM	DATE	ITEM		DATE
Y4		Y5	Y4	Y5	Y4		Y5
ID Prefix Reg. #	NFPA 101	Correction	ID Prefix Reg. #	Correction	ID Prefix Reg. #	NFPA 101	Correction Completed
LSC	K0029	10/16/2016	LSC K0054	10/16/2016	LSC	K0056	10/16/2016
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	Completed	Reg. #		Completed
LSC	K0066	10/16/2016	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		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #	Completed	Reg. #		Completed
LSC			LSC		LSC		
REVIEWE STATE AC		REVIEWED BY (INITIALS) GD/kfd REVIEWED BY	DATE 11/15/2016 DATE	SIGNATURE OF SURVEYOR	370	09	DATE 11/14/2016 DATE
CMS RO		(INITIALS)					
FOLLOW 9/1/2016		Y COMPLETED ON		R ANY UNCORRECTED DEFICIEN CTED DEFICIENCIES (CMS-2567)			YES 🗌 NO



Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Please note, These state orders should have been issued at the time of the first survey on September 2, 2016. Therefore, there will be no penalty assessments for these state orders.

November 15, 2016

Mr. Reid Hewitt, Administrator Texas Terrace Care Center 7900 West 28th Street Saint Louis Park, MN 55426

Re: Project # S5187025

Dear Mr. Hewitt:

On October 27, 2016, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 2, 2016.

State licensing orders issued pursuant to the last survey completed on September 2, 2016 and found corrected at the time of this October 27, 2016 revisit, are listed on the State Form: Revisit Report Form.

New state licensing orders are as follows:

F0565 MN Rule 4658.0405 Subp. 3 -- Comprehensive Plan Of Care; Use F0830 MN Rule 4658.0520 Subp. 1 -- Adequate and Proper Nursing Care; General F0900 MN Rule 4658.052 Subp. 3 -- Rehab - Pressure Ulcers

The details of the violations noted at the time of this revisit completed on October 27, 2016 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. Please send to :

Gloria Derfus, Unit Supervisor Minnesota Department of Health P.O. Box 64900

An equal opportunity employer

Texas Terrace Care Center November 15, 2016 Page 2

St. Paul, Minnesota 55164-0900 gloria.derfus@state.mn.us Telephone: (651) 201-3792 Fax: (651) 215-9697

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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.

Sincerely,

Kumala Fiske Downing

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

Enclosure

cc: Licensing and Certification File Shellae Dietrich, Licensing and Certification Program Penalty Assessment Deposit Staff Texas Terrace Care Center November 15, 2016 Page 3

Minneso	ta Department of He	alth			1 OT IM	///////////////////////////////////////
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00144	B. WING			२ 2 7/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	TER	ST 28TH STR DUIS PARK, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 000}	Initial Comments		{2 000}			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance.	hether a violation has been				
		ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	INITIAL COMMENT	rs:				
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			
Vinnesste D		omprehensive plan of care personnel involved in the				
ABORATOR	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

XYMH12

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00144	B. WING	B. WING		R 10/27/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE			
EXAS T	FERRACE CARE CEN	TER	ST 28TH STRI OUIS PARK, M				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
2 565	Continued From pa	age 1	2 565				
	care of the residen	t.					
	by: Based on observat review, the facility f planned interventio	ent is not met as evidenced ion, interview and document failed to implement care ins for 1 of 3 residents (R148) sustained multiple falls in the					
	facility. findings include:						
	R148's significant of (MDS), dated 10/7/ cognitively impaired bladder, and requir grooming, toileting, Care Area Assessmindicated R148 was history of falls, bala medication use and care plan for intervidated 10/13/16, ide facility and included Auto locking brakes from rolling backwas	change Minimum Data Set (16, indicated he was severely d, incontinent of bowel and ed assistance with dressing, , transfers and bed mobility. A nent (CAA) dated 10/7/16, s at risk for falls related to a ance impairment and d directed staff to refer to his entions. R148's care plan entified a history of falls in the d the following interventions: s to prevent the wheel chair ards upon standing, grab bars, od pressures weekly.					
	Notes dated 9/2/16	Ferrace Care Center Progress through 10/26/16 indicated ore than twelve falls without since 9/2/16.					
	R148 was self prop standard wheel cha	tion on 10/27/16, at 8:06 a.m., pelling on the unit. He was in a air with no auto locking brakes vation of R148's room identified					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00144	B. WING			R 10/27/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
TEXAS T	ERRACE CARE CEN	11 F R	ST 28TH STRI OUIS PARK, M				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	age 2	2 565				
	grab were not plac	e on his bed.					
	Administration Rec indicated orthostat completed weekly 10/3/16 and 10/10/ only completed wh sitting up. No stand	s Terrace Medication cord dated October 2016 ic blood pressures were to be for R148 however, on both /16, the blood pressures were ile R148 was lying down and ding blood pressures were 17/16 and 10/24/16, there was / blood pressures.					
	licensed practical r resident falls the n incident report and (IDT) reviews each the IDT reviews it v locking brakes wou R148's chair from stood. LPN-C verif had not been appli LPN-C further verif	v on 10/26/16, at 11:40 a.m., hurse (LPN)-C stated after a urse on the floor completed an I the interdisciplinary team In fall. She stated during one of was determined that auto uld be implemented to prevent rolling backwards when he ied the auto-locking brakes ed to R148's wheel chair. fied the orthostatic blood been completed as directed in					
	director of nursing have had grab bar to the orthostatic b stated they should instead of weekly,	v on 10/26/16, at 1:49 p.m., the (DON) stated R148 should s placed on his bed. In regard lood pressures, the DON have been changed to monthly but stated they should have they were on the medication et.					
	registered nurse co have had auto lock chair. She stated th	v on 10/26/16, at 1:49 p.m., the onsultant stated R148 should king brakes applied to his whee he facility did not have them in d been ordered the previous	91				

	<u>ta Department of Herror Department of Herror Department</u> OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
				A. BUILDING:		R	
		00144	B. WING		10/	10/27/2016	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
TEXAS T	ERRACE CARE CEN		ST 28TH STRE OUIS PARK, M				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE	
2 565	Continued From pa	age 3	2 565				
	day, 15 days after the care plan.	the intervention was listed on					
	Assessment and M July 2015 was revi- to implement a fall resident's needs an	d Risk Reduction: Fall/Injury Ianagement Care Plan, dated ewed. The policy directed staff /injury care plan based on the nd revise the care plan as he likelihood of another fall.					
	The administrator of system to educate	THOD OF CORRECTION: or designee could develop a staff and develop a monitoring staff are providing care as ten plan of care.					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one	9				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830				
	receive nursing can custodial care, and individual needs ar the comprehensive plan of care as de 4658.0405. A nurs of bed as much as written order from	general. A resident must re and treatment, personal and supervision based on ad preferences as identified in e resident assessment and scribed in parts 4658.0400 and sing home resident must be our possible unless there is a the attending physician that the ain in bed or the resident n bed.	d t				
	This MN Requirem by:	ent is not met as evidenced					

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COM	FLETED
		00144	B. WING		R 10/27/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	IFR	ST 28TH STR			
		SAINT LO	UIS PARK, N	IN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 4	2 830			
	review, the facility f interventions for 1 of	ion, interview and document ailed to implement of 3 residents (R148) reviewed sustained multiple falls in the				
	findings include:					
	(MDS), dated 10/7/ cognitively impaired bladder, and requir grooming, toileting, Care Area Assessn indicated R148 was history of falls, bala	change Minimum Data Set 16, indicated he was severely d, incontinent of bowel and ed assistance with dressing, transfers and bed mobility. A nent (CAA) dated 10/7/16, s at risk for falls related to a nce impairment and d directed staff to refer to his entions.				
	Notes dated 9/2/16	errace Care Center Progress through 10/26/16, indicated ore than twelve falls without since 9/2/16.				
	Occurrence dated s sustained a fall atter A Texas Terrace Oc indicated R148 fell his wheel chair. A T dated 9/14/16, indic transfer from his wh Terrace Occurrence another fall reporte unwitnessed by sta Occurrence dated s	titled Texas Terrace 9/2/16, indicated R148 empting to get to the bathroom. ocurrence dated 9/5/16, attempting to self transfer into Texas Terrace Occurrence cated he fell attempting to neel chair to his bed. A Texas e dated 9/27/16, indicated d by the resident but ff. A Texas Terrace 9/28/16, indicated resident was his bed. On 9/30/16, an				
	untitled document of fell again while atte	dated 9/30/16, indicated R148 mpting to self transfer. A urrence dated 10/1/16,				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		00144	B. WING			R 10/27/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
TEXAS T	ERRACE CARE CEN		ST 28TH STRI OUIS PARK, M				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 5	2 830				
	chair to his bed. A dated 10/9/16, india his bathroom 2 day Occurrence dated while attempting to On 10/17/16, a Tex indicated he was for a housekeeper. An Occurrence dated attempting to trans Texas Terrace Occ found on the floor b A review of R148's identified a history included the follow brakes to prevent t	care plan dated 10/13/16, of falls in the facility and ing interventions: Auto locking he wheel chair from rolling anding, grab bars, and	/				
	During an observat R148 was self prop standard wheel cha in place. An observ	tion on 10/27/16, at 8:06 a.m., belling on the unit. He was in a air with no auto locking brakes vation of R148;s room identified in place on his bed.	k				
	Administration Rec indicated orthostati completed weekly 10/3/16 and 10/10/ only completed wh sitting up. No stand	s Terrace Medication cord dated October 2016 ic blood pressures were to be for R148 however, on both 16, the blood pressures were ile R148 was lying down and ding blood pressures were 17/16 and 10/24/16, there was blood pressures.					
	licensed practical r	v on 10/26/16, at 11:40 a.m., nurse (LPN)-C stated after a urse on the floor completed an					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING: _	·····			
		00144	B. WING	B. WING		R 10/27/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
TEXAS T	ERRACE CARE CEN	11 F R	ST 28TH STRI OUIS PARK, M				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 830	Continued From pa	age 6	2 830				
	(IDT) reviews each the IDT reviews it v locking brakes wou R148's chair from stood. LPN-C verif had not been appli LPN-C further verif	the interdisciplinary team fall. She stated during one of was determined that auto uld be implemented to prevent rolling backwards when he ied the auto-locking brakes ed to R148's wheel chair. fied the orthostatic blood been completed as directed in					
	director of nursing have had grab bars to the orthostatic b stated they should instead of weekly,	v on 10/26/16, at 1:49 p.m., the (DON) stated R148 should s placed on his bed. In regard lood pressures, the DON have been changed to monthl but stated they should have they were on the medication et.					
	registered nurse co have had auto lock chair. She stated the stock and they had	v on 10/26/16, at 1:49 p.m., the onsultant stated R148 should king brakes applied to his whee he facility did not have them in I been ordered the previous he intervention was listed on					
	Injuries Program, c The policy indicate the risk for falls an implementation of provide an environ	d Risk Reduction: Falls and dated July 2015 was reviewed. d the center strives to reduce d injuries by promoting the the falls and injuries program, ment free form hazards and evices to prevent avoidable					
	The director of nur	THOD OF CORRECTION: sing (DON) or designee could sure each resident is assessed	Ŀ				

Minnesc	ta Department of He	alth			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00144	B. WING			R 2 7/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	TER	ST 28TH STR DUIS PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 7	2 830			
	or designee could t	and supervision. The DON hen perform audits to ensure ves the care and supervision res.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				
2 900	MN Rule 4658.0525 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	receives necessary	ho has pressure sores y treatment and services to revent infection, and prevent veloping.				
	by: Based on observati review the facility fa assess and identify residents (R106), re	ent is not met as evidenced on, interview and document illed to comprehensively pressure ulcers for 1 of 3 eviewed for nutritional risk but e ulcers in the facility.				
	Findings include:					
Minnesota D	epartment of Health					

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
	OF CONTLETION	IDENTIFICATION NOMBER.	A. BUILDING: _	<u></u>			
		00144	B. WING			R 10/27/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
TEXAS 1	ERRACE CARE CEN	11 F R	ST 28TH STRI DUIS PARK, M				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 900	Continued From pa	age 8	2 900				
	R106's quarterly Minimum Data Set (MDS) dated 10/16/16, indicated the resident had severe cognitive impairment, was always incontinent of bowel and bladder, required extensive assist with bed mobility, transfers and was at risk for pressure ulcers but did not currently have a pressure ulcer.						
	1/22/16, indicated assist of one for to brief, required assi skin breakdown an ulcer "resolved" 1/2	Assessment (CAA) dated R106 was incontinent of bowel, ileting, required an incontinent st with bed mobility, at risk for ad had a stage four pressure 4/16. The CAA indicated the low or minimize decline, avoid minimize risks.					
	sitting in his wheeld On 10/26/16, at 10 sitting in his wheeld water out of a two he had been eating On 10/27/16, at 7:5 sitting in his wheeld R106 waved at sur stated "my bottom staff person]?." "[A identified as the ac the floor. The conv time to A and licens	251 a.m., R106 was observed chair in the dayroom drinking handled lid cup. R106 stated g "pretty good." 59 a.m., R106 was observed chair at a dining room table. rveyor and when approached, hurts, can you tell [activities ctivities staff person]" was stivities (A) "go to" person on rersation was reported at this sed practical nurse (LPN)-C					
	ulcer." On 10/27/16 at 8:4 still be in dining roc asked how breakfa eat my bottom hurt got tears in his eye LPN-C who stated	does not have a pressure 4 a.m. R106 was observed to om eating breakfast. When ast was, R106 stated "I can't ts so much" at which time R106 es. This was again reported to "I repositioned him and the NA morning did not tell me there					

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		BERTH TOTATION HOMBEN.	A. BUILDING:	·····		
		00144	B. WING		R 10/27/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, S	TATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN		ST 28TH STRI DUIS PARK, M			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	(EACH DEFICIENC REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	age 9	2 900			
	breakfast." On 10/27/16, at 9:3 and stated "I'm bet grab bar but was u LPN-C used grab I A Stage II pressure loss involving epide ulcer is superficial abrasion, blister, or was observed to be centimeter (cm) wit tissue. Barrier crea LPN-C stated "yes LPN-C stated she ulcer, "no one has R106's care plan d weekly skin assess Risk Assessment (pressure ulcers) of risk of developing p issues since last re transfers. The care sheet to move resid turning if area of re avoid positioning o pressure reduction chair and bed and Review of two EHS	g. I will check his bottom after 39 a.m. R106 was laying in bed ter now." R106 reached for nable to reposition himself. ift sheet to roll him to his side. e ulcer (partial thickness skin ermis, dermis, or both. The and presents clinically as an r shallow crater) on the coccyx e approximately 2.0 X .5 th non-blanchable surrounding im was on the coccyx area. , that's greasy." At 9:42 a.m. was not aware of the pressure told me." ated 10/14/16, indicated the sment was reviewed, Braden level of risk for development of 17 on 8/8/16 indicating a mild pressure ulcer, no skin/wound eview and was one assist for e plan directed staff to use lift dent, increase frequency of edness is non-blanchable, n trochanter (thigh bone), or pressure relief surface for apply topical skin protectant. SI Skin Assessments, both dicated there were no "no				
	areas of impairmer Review of a Brader dated 10/14/16, inc					
		ing aide 2nd Floor Team 5 care 8/31/16, indicated R106 was				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00144	B. WING			R 10/27/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
TEXAS 1	ERRACE CARE CEN		ST 28TH STRI OUIS PARK, M				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE	
2 900	Continued From pa	age 10	2 900				
		ansfers and bed mobility and nd repositioned every two					
	indicated to conduct day (Friday PM) an	n orders dated October 2016, ct a weekly skin check on bath nd apply dimethacone cream to y (however this was 26/16).					
		n order dated 10/10/16, ster 120 milliliter house a day.					
	September 2016, in ordered weekly ski Three of four physi checks for October Allevyn dressing to other day] and prn	tment Order Sheets for ndicated two of five physician n checks were not completed. ician ordered weekly skin r 2016 were not completed. o coccyx, "change QOD [every (as needed), cleanse with NS as added on 10/27/16.					
	nursing aide (NA)-/ a little red yesterda and today she put l because the "botto yesterday. NA-A st and normally he do the chair, so "I laid	n 10/27/16, at 10:31 a.m. A stated she saw the area was by but she did not tell the nurse barrier cream on the "sore" m" looked different today than ated she had washed him up besn't complain until he sits in him down in bed." NA-A stated st of two with the EZ stand and ange" for toileting.					
	R106 stated his bo awhile ago", but wa ago that was. R106 the room stated he	v on 10/27/16, at 11:44 a.m. ttom started to hurt "quite as unable to state how long 5's spouse (S)-A who shares had an "abscess before, quite ated she was "after" the aides					

TATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION			
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED		
		00144	B. WING			R 10/27/2016	
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
EXAS T	ERRACE CARE CEN	IIEB	ST 28TH STRI OUIS PARK, M				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 900	Continued From pa	age 11	2 900				
	wheelchair from af	cause he was sitting in his ter lunch until the pm shift. S-A fy when the incident happened					
	LPN-C stated R100 areas on his coccy but doesn't like to I got the tilt wheelch LPN-C stated R100 9/2/16, and has no although he had ar on his IT, "he could was not aware unti	n 10/27/16, at 12:55 p.m. 6 has had "on and off open x and ischial tuberosity (IT)" ay down", so that is when they air so he could lay back. 6 has had no wounds since t had any for many months, n abscess many months ago d hardly sit." LPN-C stated she I now about the pressure ulcer pected the aides to tell her, red."					
	administrator state had cared for R106 pm shifts and night cared for R106 on shifts. R106 was gi noticed some redn because it was close cream in the room, every time R106 w report this to anyor night shift he notice with soap and wate and did not tell the should have. Admi should have been four different opport the initial skin redn	n 10/27/16, at 3:08 p.m. d another nursing aide, NA-B 5 on 10/25/16, and 10/26/16, t shift on 10/26/16, and NA-A 10/26/16 and 10/27/16, am iven a bath on 10/25/16, NA-B ess on the coccyx, but sed and there was barrier , he did use it and reapplied it as repositioned. NA-B did not ne. NA-B stated on 10/26/16, ed "some splitting", washed it er, did not use barrier cream night nurse, but stated he nistrator verified any redness reported and that there were rtunities for the aides to report ess and then consequent oper rx to nursing since 10/25/16.	n				
	Treatment procedu	ity Wound Prevention and ure dated July 2015 indicated rs all residents as at risk for					

Minnesc	ta Department of He	ealth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00144	B. WING		F 10/2	₹ 2 7/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	IFR	ST 28TH STF DUIS PARK, I			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	interventions to pre pressure ulcers: "re over bony prominer against the adverse mechanical forces increase the aware prevention through Weekly Skin Asses 2015, indicated the complete a weekly includes a head to residents skin, doct including the location to monitor until head A wound assessme 10/27/16, was requined SUGGESTED MET The Director of Nur assure policies and implemented, and r staff reassess, and pressure ulcers.	d will implement the following vent the development of educe occurrence of pressure nce to minimize injury, protect e effects of external (pressure, friction, shear) and ness of pressure ulcer educational programs." The sment procedure dated July facility requires staff to skin assessment which toe visualization of the umenting any impairment, on, type and size, and the need	2 900			
Minnesota D	epartment of Health					

STATE FORM: REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building			DATE OF REVI	SIT
	B. Wing		Y2	10/27/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
TEXAS TERRACE CARE CEN	TER	7900 WEST 28TH STREET			
		SAINT LOUIS PARK, MN 55426			

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

ITE Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	:
ID Prefix Reg. #	20255 MN Rule 4658.0070	Correction	ID Prefix 20	0300 N Rule 4658.0105	Correction Completed	ID Prefix Reg. #	20560 MN Rule 4658.04 Subp. 2	Correctors	
LSC		10/16/2016	LSC		10/16/2016	LSC		10/16/2	
ID Prefix Reg. # LSC	20570 MN Rule 4658.0405 Subp. 4	Correction Completed		0965 N Rule 4658.0600 ubp. 2	Correction Completed 10/16/2016	ID Prefix Reg. # LSC	21390 MN Rule 4658.08 Subp. 4 A-I	00 Correc 10/16/2	leted
ID Prefix Reg. # LSC	21426 MN St. Statute 144A Subd. 3	Correction .04 Completed 10/16/2016		1540 N Rule 4658.1315 ubp. 2	Correction Completed 10/16/2016	ID Prefix Reg. # LSC	21670 MN Rule 4658.14 A.B.C.D.	Correc 05 Comp 10/16/2	leted
ID Prefix Reg. # LSC	21980 MN St. Statute 626.5 Subd. 3	Correction 57 Completed 10/16/2016		2000 N St. Statute 626.557 ubd. 14 (a)-(c)	Correction Completed 10/16/2016	ID Prefix Reg. # LSC		Corree Comp	
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correc	
REVIEWI STATE A		viewed by TIALS) GD/kfd	DATE 11/14/20	-	SURVEYOR	35569)	DATE 10/27/2010	6
REVIEWI CMS RO	ED BY REV	VIEWED BY TIALS)	DATE	TITLE				DATE	
FOLLOW 9/2/2016	VUP TO SURVEY CO	MPLETED ON		K FOR ANY UNCORREC RRECTED DEFICIENCI				🗆 YES 🗖	NO

DEPARTMENT OF HEAL	TH AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
	MEDIC	ARE/MEDICAI	D CERTIFIC	CATION A	AND TRANSMITTAL	ID: XYMH
	PART I -	TO BE COMPI	LETED BY T	'HE STAT	TE SURVEY AGENCY	Facility ID: 00144
1. MEDICARE/MEDICAID PROVI NO.(L1) 245187	IDER	3. NAME AND AD (L3) TEXAS TER			1	4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification
2. STATE VENDOR OR MEDICAL (L2) 276542000	ID NO.	(L4) 7900 WEST (L5) SAINT LOU			(L6) 55426	3. Termination4. CHOW5. Validation6. Complaint
 5. EFFECTIVE DATE CHANGE OF (L9) 07/01/2015 	FOWNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
	/02/2016 ^(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other	A	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
11LTC PERIOD OF CERTIFICATION	ON	10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b):		Program Re			2. Technical Personnel	6. Scope of Services Limit
		Compliance	e Based On:		3. 24 Hour RN	7. Medical Director
12 Total Easility Pada	118 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	NF) 8. Patient Room Size
12. Total Facility Beds	,	V. D. M. H. G.			5. Life Safety Code	9. Beds/Room
13.Total Certified Beds	118 (L17)	X B. Not in Con Requirements	and/or Applied V		* Code: B	(L12)
14. LTC CERTIFIED BED BREAKD	DOWN				15. FACILITY MEETS	
18 SNF 18/19 SNI 118	F 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY RE	MARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Amy Charais, HFE	NE II	1	0/17/2016	(L19)	Kamala Fiske-Downing,	, Enforcement Specialist 10/24/2016 (L20
PA	ART II - TO BE	COMPLETED H	BY HCFA RE	GIONAL	OFFICE OR SINGLE S	
19. DETERMINATION OF ELIGIB	ILITY		IPLIANCE WITH ITS ACT:	I CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
1. Facility is Eligible to	Participate	Rior	no ker.		3. Both of the Above	
2. Facility is not Eligit	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	IENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION 02/01/1978	BEGINNING	J DATE	ENDING DAT	ſΈ	VOLUNTARY 00 01-Merger, Closure	DINVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	ement 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	on <u>OTHER</u>
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	P. Descind St	uspension Date:	(L44)			00-Active
	D. Reschid S	uspension Date.	(L45)			
28. TERMINATION DATE:	29). INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		06301				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE		
	(L32)			(L33)	DETERMINATION APP	ROVAL

CENTERS FOR MEDICARE & MEDICARE CERTIFICA



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

September 23, 2016

Mr. Reid Hewitt, Administrator Texas Terrace Care Center 7900 West 28th Street Saint Louis Park, MN 55426

RE: Project Number S5187025 and Complaint H5187072

Dear Mr. Hewitt:

On September 2, 2016, an extended 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) whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed. In addition, at the time of the September 2, 2016 extended survey the Minnesota Department of Health completed an investigation of complaint number H5187072 that was found to be unsubstantiated.

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

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

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

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

DEPARTMENT CONTACT

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

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

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when they have deficiencies of Substandard Quality of Care (SQC) that are not immediate jeopardy and are identified on the current survey. The current 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) whereby corrections are required. Your facility meets the criterion and remedies will be imposed immediately pursuant to a survey completed on September 2, 2016. Therefore, this Department is imposing the following remedy:

• State Monitoring effective September 28, 2016. (42 CFR 488.422)

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

• Per instance civil money penalty for the deficiency cited at F226, Effective September 23, 2016. (42 CFR 488.430 through 488.444)

Texas Terrace Care Center September 23, 2016 Page 3 The CMS Region V Office will notify you of their determination regarding our recommendations.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Texas Terrace Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective December 2, 2016. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <u>https://dab.efile.hhs.gov</u> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services Departmental Appeals Board, MS 6132 Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201 (202) 565-9462

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

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,
 - Include electronic acknowledgement signature of provider and date.

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 ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 December 2, 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 March 2, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	1		0	MB NO.	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245187	B. WING			09/	02/2016
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	TER			000 WEST 28TH STREET AINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 0	00			
	signature is not req page of the CMS-2	led in ePOC and therefore a uired at the bottom of the first 567 form. Electronic POC will be used as bliance.					
	revisit of your facilit validate that substa	acceptable POC an on-site y may be conducted to Intial compliance with the en attained in accordance with					
		complaint, H5187072 was nplaint was not substantiated.					
		y was conducted by the nent of Health on 8/29/16 to					
F 225 SS=E		PORT	F 2	25			10/12/16
	been found guilty or mistreating residen had a finding entered registry concerning of residents or mise and report any know court of law against indicate unfitness for other facility staff to or licensing authorit The facility must en involving mistreatm	sure that all alleged violations ent, neglect, or abuse,					
	including injuries of	unknown source and					
		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
Electron	ically Signed						09/30/2016

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.

PRINTED: 10/17/2016

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE (COMPI	
				i		
		245187	B. WING		09/02	2/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS 1	ERRACE CARE CEN	TER		7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 225	misappropriation of immediately to the to other officials in a through established State survey and ce The facility must ha violations are thoro prevent further pote investigation is in p The results of all in to the administrator representative and with State law (inclu certification agency incident, and if the a appropriate correct	resident property are reported administrator of the facility and accordance with State law d procedures (including to the ertification agency). we evidence that all alleged ughly investigated, and must ential abuse while the rogress. vestigations must be reported to other officials in accordance uding to the State survey and) within 5 working days of the alleged violation is verified ive action must be taken.	F 225			
	by: Based on interview facility failed to imm abuse to the design accordance with fac (R29, R75, R19, R1 by facility staff. Findings include: R29's admission M 6/24/16, indicated s required extensive daily living. R29's c her as a vulnerable abuse/neglect. The	NT is not met as evidenced y and document review, the hediately report allegations of hated State agency (SA) in cility policy for 4 of 6 residents (0) who alleged mistreatment inimum Data Set (MDS) dated she was cognitively intact and assistance with activities of are plan dated 6/16 identified adult and at risk for care plan directed staff to symptoms of abuse and		Preparation, submission and implmentation of this Plan of Correct does not constitute an admission of agreement with the facts and conclu- in the statement of deficiencies. Thi of Correction is prepared and execu- a means to continuously improve th quality of care, to comply with all applicable state and federal regulator requirements and it constitutes the facility's allegation of comliance. 1. Resident #10, #19, #29, and #75 greivances have been reviewed and reported to the state agency. 2. Resident allegations are being re	, or usion s Plan ited as e ory	

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
		245187	B. WING	NG.			
	PROVIDER OR SUPPLIER	243107	D. WING_	S	TREET ADDRESS, CITY, STATE, ZIP CODE	09/0	02/2016
	ERRACE CARE CEN	ITER		7	900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 225	Continued From pa	age 2	F 22	25			
	On 8/29/16, at 10:1 roommate (R29) has member approximal staff member made and laughed at her On 8/30/16, at 6:31 assistant (NA)-B tro and spoke to her in stated NA-B came embarrassed her in room. R29 stated s following the incide taunting her. R29 s on her unit and she medications, but th	gate concerns per policy. 10 a.m. R96 reported her ad been abused by a staff ately one week prior, when a e her wait for her medications 1 p.m. R29 stated nursing eated her unprofessionally, n "an abusive manner." She at her in a loud tone and n front of everyone in the dining she cried for five hours ent and felt he was intentionally stated NA-B was still working e preferred he not give her ere was no other option. She d a complaint and gave it to			to the Executive Director, Director Nursing Services and reported to t agency as required. 3. Staff will be re-educated regardi reporting and investigating allegati mistreatment, neglect, abuse, injur unknown orgin, and misappropriati resident property by 10/12/2016. 4. NHA/Designee will audit up to 2 allegations per week for implemen and investigation per policy for 1 m continued audits of 2 allegations w completed monthly until discontinu QAPI. Results of audit shared at C	he state ng ons of ries of ion of tation nonth ill be ed by	
	8/17/16, indicated I regarding NA-B wh the concern form F "mentally abusive" enough problems w report indicated the request for pain me indicated after spea director (ED) felt he abuse/neglect." Th "trying to manipulat is typical of her hist	-					
	ED stated he was a abuse by R29. He	y on 8/13/16, at 11:29 a.m. the aware of the allegation of stated he was able to speak to the same day the incident					

If continuation sheet Page 3 of 82

		AND HUMAN SERVICES				FORM	10/17/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245187	B. WING			09/	02/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS 1	ERRACE CARE CEN	TER			900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	occurred. He furthe well and had receiv when asked what h had gotten "firm wit administrator stated we were able to un- abuse." During a su p.m. The ED stated been reported to the R75's quarterly MD had moderately imp also identified R75 of two staff for dres and bed mobility. R75's careplan date vulnerable adult wit identified his cognit and further indicate own concerns. The to report and invest A resident concern R75 had filed a con another NA who has stated staff had bee to his request to us reported that NA-F on 7/4/16 told R75 the did not want to c use the bathroom. signed by the ED on report" on the secon administrator had s about toileting, and tell a resident to go investigation further	er stated he knew NA-B very red no concerns. He stated happened, NA-B had stated he th her [R29]." The d, because of R29's past, "I felt -substantiate the mental ubsequent interview at 1:58 d the incident should have e SA. S dated 8/9/16, identified R75 paired cognition. The MDS required extensive assistance using, repositioning, toileting ed 7/5/16, identified R75 as a th cognitive impairment, ion status as easily distracted, ed R75 was able to voice his care plan further directed staff tigate all concerns per policy. report dated 7/5/16, indicated neern regarding NA-F and d worked on 7/4/16. R75 en taking 2-3 hours to respond e the bathroom. It was also and another aide who worked to "go in his briefs." R75 stated do that and wanted to instead The concern report had been n 7/5/16. The "Investigation nd page indicated the spoken with NA-F on 7/6/16 NA-F stated she would never		225			

Facility ID: 00144

If continuation sheet Page 4 of 82

		AND HUMAN SERVICES				FORM	10/17/2016 APPROVED 0938-0391
STATEMENT OF DEFINAND PLAN OF CORRE	CIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245187	B. WING			09/(02/2016
NAME OF PROVIDER	R OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
TEXAS TERRAC		TED		79	900 WEST 28TH STREET		
IEAAS IERRAC	E CARE CEN	IER		S	AINT LOUIS PARK, MN 55426		
	ACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
held w was "c dated include undate reside in their includi An inte reveal the SA conce "un-su conce NA-F o he had conce allowe R19's indicat compl a male of [R1] her un conce wante times. 8/8/16 who in at 6:07 reside (4:00 a time o the bri the ca female	overall satisfie 7/21/16. Cor ed a "Golden ed with the su ents to the bat r briefs" which ing NA-F. erview with th led R75's con A. The ED sta rn immediate ubstantiated" t rn to the SA. did not provid d spoken with rn was not su ed to continue Resident Cor ted "[R19's] d aint about he e NA last nigh 9] was rough nder garment. rns about mo d resident to " The inves 6, a telephone ndicated he ha 7 p.m. to ask ent had asked a.m.). NA the f day and ask ief and R19 th res, R19 neve e NA and neve	The investigation was mponents of the investigation Rod" (education sheet) ubject: "We always take throom. Never ask them to go h had been signed by six NAs, the ED on 9/2/16, at 8:36 a.m. the en had not been reported to the had investigated the ely and found the concern to be therefore, did not report the The ED went on to say that de cares to other residents until ther on 7/6/16, and since the ubstantiated, NA-F had been		225			

Facility ID: 00144

If continuation sheet Page 5 of 82

	-	AND HUMAN SERVICES				FORM	APPROVED
	<u>RS FOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES			E CONSTRUCTION		0938-0391 E SURVEY
-	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245187	B. WING	-		00//	02/2016
NAME OF F	PROVIDER OR SUPPLIER	240101		S	TREET ADDRESS, CITY, STATE, ZIP CODE	09/0	02/2016
TEVACT	ERRACE CARE CEN	TED			900 WEST 28TH STREET		
TEAST	ENNACE CARE CEN			S	AINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	Continued From pa	ige 5	F 22	25			
	In the investigation, 8/8/16, and was asl received good care if she felt comfortation her over the last 24 "No." However, during a desire to move to preferred a female On 9/1/16, at 11:26 interviewed and revered report for R19. The not reported to the done the same day and that the NA in or describe in depth the R19 was confused and offered no context we took our 24 hou R19's annual MDS had moderately implication have any psychosis In addition, R19's d and anxiety. The cond dated 6/16, identified perception, was a v interviewable and m The care plan direct and investigate per	 , R19 had been interviewed on ked if she felt she had so over the last 24 hours "Yes," ole with everyone who gave d if she felt anyone had hurt hours and resident stated ing the interview R19 reported second floor and stated she NA. a.m. ED and DON were viewed regarding the concern ED stated the concerns was SA, as the investigation was the facility was made aware, question had been able to he cares provided. ED stated and unable to give specifics others had been interviewed cerns. ED further stated, "We ed it immediately instead, but rs to investigate." dated 6/17/16, indicated R19 paired cognition and did not so, delusions, or hallucinations. liagnoses included dementia ognitive assessment care plan ed R19 had periods of altered vulnerable adult, was noderate impaired cognition. 					
	reported to a staff s	10's behalf indicated R158 had seeing a staff person "push ulders in her room about a					

If continuation sheet Page 6 of 82

PRINTED: 10/17/2016

		AND HUMAN SERVICES				FORM	10/17/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245187	B. WING			09/	02/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
TEXAS T	ERRACE CARE CEN	TER			900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	Continued From pa week ago."	ge 6	F 2	225			
	had been interviewe reported "a week ag [NA-E] pushed dow	dated 6/2/16, indicated R158 ed at 4:15 p.m. and had go or so in the dining room n on [R10's] shoulders when her chair and god dammit I ."					
	sheet indicated both R158's accusation substantiated for all and family member witnessed NA-E or inappropriately. The was at time agitated and staff did try to s	disposition of the concern h the ED and DON agreed was immediately not buse/neglect per staff, resident s, and no one had ever any other staff treat R10 e report further indicated R10 d, was a fall risk and impulsive stop her from getting up out of but not in a malicious way and ring at any resident.					
	R10 had severely ir	DS dated 5/19/16, indicated npaired cognition with /andering behavior was					
	displayed extreme l stealing his medica unreliable reporter. shift had been calle identified as very in falling. The ED indie nursing station, and when R10 stood, N okay. what do you r bathroom?" When a have been reported	a.m. the ED stated R10 behaviors, accusing staff of tions, causing a stir and was a The ED indicated staff on the ed in and interviewed. R10 was pulsive and at high risk for cated NA-E was behind d resident was behind the table A-E rushed over and said "It's need? Do you need the asked if the allegation should t to the SA the ED stated "We ed it first and but we were able					

If continuation sheet Page 7 of 82

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/17/2016 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY IPLETED
		245187	B. WING			09/	02/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	TER			900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	The facility's 7/15, F	ge 7 abuse in the first 24 hours." Prevention and Reporting: ent, Neglect, Abuse, Including	F 2	25			
	injuries of unknown of Resident Propert allegations that mee substantiated violat agencies and to all local law enforceme Adult Protective Se takes all necessary on the result of the The center requires alleged violations to DON/designee imm as soon as possible	source, and Misappropriation ty policy directed "All et the definition of abuse and ions will be reported to state other agencies including the ent, elder abuse agencies, and rvices, as required. The center corrective actions depending					
F 000	shorter state time fr Neglect is failure to necessary to avoid anguish, or mental instances of abuse/ those in a coma, ca mental anguishM Includes, but is not harassment, and th deprivationProtect immediate safety of identification of pote mistreatment, injuri misappropriation of non-employee imm Suspend identified pending outcome of	rame requirementNeglect: provide goods and services physical harm, mental illness. This presumes that 'neglect of all residents, even use physical harm, pain, or ental/Emotional abuse: limited to, humiliation, reats of punishment or tion 1. Provide for the f the resident upon ential abuse, neglect, es of unknown source, and/or property. Require identified ediately leave the center. employee(s) immediately f the investigation"	5.0				10/10/10
F 226 SS=F	483.13(c) DEVELO ABUSE/NEGLECT,		F 2	26			10/12/16

If continuation sheet Page 8 of 82

DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X3) DATE	SURVEY
CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	B	COMF	PLETED
	245187	B. WING		09/0	2/2016
OVIDER OR SUPPLIER					
RACE CARE CEN	TER				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETIC DATE
he facility must de olicies and proced histreatment, negli nd misappropriation his REQUIREME Sased on interview acility failed to ope egarding investiga of the designated S esidents (R29, R7 histreatment by sta otential to affect a indings include: he facility's 7/15, I esident Mistreatm juries of unknowr f Resident Proper llegations that me ubstantiated viola gencies and to all ocal law enforcem dult Protective Se kes all necessary n the result of the he center requires lleged violations to ON/designee imm s soon as possible	Avelop and implement written dures that prohibit ect, and abuse of residents on of resident property. NT is not met as evidenced w and document review, the erationalize their facility policy tion and immediate reporting State agency (SA) for 4 of 6 5, R19, R10) who alleged aff. These practices had the ull 101 residents in the facility. Prevention and Reporting: nent, Neglect, Abuse, Including n source, and Misappropriation ty policy directed "All et the definition of abuse and tions will be reported to state other agencies including the ent, elder abuse agencies, and ervices, as required. The center of corrective actions depending investigation. s centers to report these of the executive director and nediately. 'Immediately' means e, but not to exceed 24 hours	F 226	 Resident #10, #19, #29, and # greivances have been reviewed a reported to the state agency. Potential allegations are being to to the Executive Director and Dire Nursing Services and reported to agency as required. Staff will be re-educated regard reporting and investigating allegat mistreatment, neglect, abuse, inju unknown orgin, and misapporpria resident property by 10/12/2016. NHA/Designee will audit up to 2 allegations per week for implement policy and audit 3 staff members p to assure policy understanding for month. Continue audits of 2 allegation and 3 aud month of staff understanding until 	nd reported ctor of the state ling ions of ries of tion of patation of per week one ations its per	
	DVIDER OR SUPPLIER RACE CARE CEN SUMMARY STA (EACH DEFICIENC' REGULATORY OR L ontinued From pa he facility must de olicies and proced istreatment, neglind misappropriation his REQUIREME y: Based on interview acility failed to ope egarding investiga o the designated S esidents (R29, R7 histreatment by sta otential to affect a indings include: he facility's 7/15, I esident Mistreatm juries of unknowr f Resident Proper legations that me ubstantiated violar gencies and to all ocal law enforcem dult Protective Se kes all necessary n the result of the he center requires leged violations to ON/designee imn s soon as possible fter discovery of in	DENTIFICATION NUMBER: 245187 245187 2010ER OR SUPPLIER RACE CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ontinued From page 8 he facility must develop and implement written olicies and procedures that prohibit instreatment, neglect, and abuse of residents and misappropriation of resident property. his REQUIREMENT is not met as evidenced y: Based on interview and document review, the ciclity failed to operationalize their facility policy agarding investigation and immediate reporting the designated State agency (SA) for 4 of 6 asidents (R29, R75, R19, R10) who alleged histreatment by staff. These practices had the otential to affect all 101 residents in the facility. indings include: he facility's 7/15, Prevention and Reporting: esident Mistreatment, Neglect, Abuse, Including juries of unknown source, and Misappropriation f Resident Property policy directed "All llegations that meet the definition of abuse and ubstantiated violations will be reported to state gencies and to all other agencies including the iccal law enforcement, elder abuse agencies, and dult Protective Services, as required. The center takes all necessary corrective actions depending n the result of the investigation. he center requires centers to report these lleged violations to the executive director and ON/designee immediately. 'Immediately' means s soon as possible, but not to exceed 24 hours fter discovery of incident, in the absence of a	EDEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIF A. BUILDING 245187 B. WING	EFFICIENCIES DORRECTION (X1) PROVIDERSUPPLERCLIA IDENTIFICATION NUMBER: 245187 (X2) MULTIPLE CONSTRUCTION A. BUILDING 245187 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 7000 WEST 28TH STREET SAINT LOUIS PARK, MN 55426 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PHOVIDER'S PLAN OF CORRECTIVE (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PL An facility must develop and implement written olicies and procedures that prohibit istreatment, neglect, and abuse of residents and misappropriation of resident property. F 226 his REQUIREMENT is not met as evidenced y: based on interview and document review, the ciclity failed to operationalize their facility policy isteratment by staff. These practices had the otential to affect all 101 residents in the facility. Indings include: Indings include: In feacility's 7/15, Prevention and Reporting: esident Mistreatment, Neglect, Abuse, including juries of unknown source, and Misappropriation in Resident Property policy directed "All legations that meet the definition of abuse and bustantiated violations will be reported to state gencies and to all other agencies including the gencies and to all other abuse agencies, and dult Protective Services, as required. The center kkes all necessary corrective actions depending in the result of the investigation. he center requires centers to report these leged violations to the executive director and ON/designee immediately. Immediately means s soon as possible, but not to exceed 24 hours for discovery of incident, in the absence of a	DEFICIENCIES CORRECTION (X1) PROVIDERSUPPLIENCLIA IDENTIFICATION NUMBER: 245187 (X2) MULTIPE CONSTRUCTION A. BUILDING (X3) DATE A. BUILDING (X3) DATE A. BUILDING 2010ER OB SUPPLIER 245187 ISTRACE CARE CENTER ISTRACE CARE CENTER

If continuation sheet Page 9 of 82

		AND HUMAN SERVICES				FORM	10/17/2016 APPROVED
STATEMENT	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION BUILDING			0938-0391 E SURVEY IPLETED
		245187	B. WING	i		09/	02/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
TEXAS 1	ERRACE CARE CEN	TER			7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	those in a coma, ca mental anguishM Includes, but is not harassment, and th deprivationProtect immediate safety of identification of pote mistreatment, injuri misappropriation of non-employee imm Suspend identified pending outcome o R29's admission M 6/24/16, indicated s required extensive daily living. R29's ca her as a vulnerable abuse/neglect. The watch for signs and neglect and investig On 8/29/16, at 10:1 roommate (R29) ha member approxima staff member made and laughed at her. On 8/30/16, at 6:31 assistant (NA)-B tre and spoke to her in stated NA-B came a embarrassed her in room. R29 stated s following the incider taunting her. R29 s on her unit and she	An eglect of all residents, even ause physical harm, pain, or ental/Emotional abuse: limited to, humiliation, reats of punishment or tion 1. Provide for the f the resident upon ential abuse, neglect, es of unknown source, and/or property. Require identified ediately leave the center. employee(s) immediately f the investigation" inimum Data Set (MDS) dated she was cognitively intact and assistance with activities of are plan dated 6/16 identified adult and at risk for care plan directed staff to l symptoms of abuse and gate concerns per policy. 0 a.m. R96 reported her ad been abused by a staff ately one week prior, when a e her wait for her medications	F	226			

Facility ID: 00144

If continuation sheet Page 10 of 82

		AND HUMAN SERVICES				FORM	: 10/17/2016 APPROVED : 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245187	B. WING	ì		09/	02/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS TERRACE CARE CENTER					7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	stated she had filed one of the staff. A review of a Resid 8/17/16, indicated F regarding NA-B whi the concern form R "mentally abusive" t enough problems w report indicated the request for pain me indicated after spea director (ED) felt he abuse/neglect." The "trying to manipulat is typical of her hist During an interview ED stated he was a abuse by R29. He s the nurses on duty occurred. He furthe well and had receiv when asked what h had gotten "firm wit administrator stated	d a complaint and gave it to lent Concern Report dated R29 had filled out a report o "repeatedly" yelled at her. In 29 had indicated NA-B was to her and stated she had vithout him yelling at her. The encident was regarding a edications. The report further aking with NA-B, the executive e could "un-substantiate e report indicated R29 was to pain meds [medications] as tory." o on 8/13/16, at 11:29 a.m. the aware of the allegation of stated he was able to speak to the same day the incident er stated he knew NA-B very yed no concerns. He stated happened, NA-B had stated he		226			
	abuse." During a su p.m. The ED stated been reported to the R75's quarterly MD had moderately imp	ubsequent interview at 1:58 I the incident should have					

If continuation sheet Page 11 of 82

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	10/17/2016 APPROVED 0938-0391
		. ,	E CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		245187	B. WING		09/(02/2016
NAME OF	PROVIDER OR SUPPLIER	•		TREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS TERRACE CARE CENTER				900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	of two staff for dres and bed mobility. R75's careplan date vulnerable adult wit identified his cognit and further indicate own concerns. The to report and invest A resident concern R75 had filed a cor another NA who ha stated staff had bee to his request to us reported that NA-F on 7/4/16 told R75 he did not want to c use the bathroom. signed by the ED o report" on the seco administrator had s about toileting, and tell a resident to go investigation furthe re-educated and in held with the reside was "overall satisfie dated 7/21/16. Cor included a "Golden undated with the su residents to the bat in their briefs" which including NA-F. An interview with the revealed R75's con the SA. The ED sta	ed 7/5/16, identified R75 as a th cognitive impairment, tion status as easily distracted, ed R75 was able to voice his care plan further directed staff tigate all concerns per policy. report dated 7/5/16, indicated neern regarding NA-F and id worked on 7/4/16. R75 en taking 2-3 hours to respond the bathroom. It was also and another aide who worked to "go in his briefs." R75 stated do that and wanted to instead The concern report had been in 7/5/16. The "Investigation ind page indicated the spoken with NA-F on 7/6/16 NA-F stated she would never				

Facility ID: 00144

If continuation sheet Page 12 of 82

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	10/17/2016 APPROVED 0938-0391	
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	(X3) DATE SURVEY COMPLETED	
		245187	B. WING		09/	02/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-		
TEXAS TERRACE CARE CENTER				7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 226	"un-substantiated" i concern to the SA. NA-F did not provid he had spoken with concern was not su allowed to continue R19's Resident Con indicated "[R19's] d complaint about he a male NA last nigh of [R19] was rough her under garment. concerns about mo wanted resident to times" The inves 8/8/16, a telephone who indicated he ha at 6:07 p.m. to ask resident had asked (4:00 a.m.). NA the time of day and ask the brief and R19 th the cares, R19 new female NA and new being or being roug In the investigation, 8/8/16, and was asl received good care if she felt comfortat her over the last 24 "No." However, dur a desire to move to preferred a female	therefore, did not report the The ED went on to say that de cares to other residents until h her on 7/6/16, and since the ubstantiated, NA-F had been e working. ncern Report dated 8/8/16, daughter wants to make a er mom being treated rough by ht 8.7.16. Aide who took care when helping with changing . Daughter stated she had om having a male NA and have a female NA at all stigative report indicated on e call was made to the male NA ad been to the resident's room if he could change her and the d him to "come back at 0400" en re-oriented resident to the ked resident if he could change hen allowed the cares. During ver stated he was hurting her or gh with pericare. , R19 had been interviewed on iked if she felt she had es over the last 24 hours "Yes," ble with everyone who gave d if she felt anyone had hurt 4 hours and resident stated ring the interview R19 reported o second floor and stated she					

Facility ID: 00144

If continuation sheet Page 13 of 82

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	10/17/2016 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245187	B. WING _			09/	02/2016		
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE	•			
TEXAS 1	FERRACE CARE CEN	TER	7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 226	interviewed and rew report for R19. The not reported to the done the same day and that the NA in or describe in depth th R19 was confused and roommate and and offered no con- should have reported we took our 24 hou R19's annual MDS had moderately imp have any psychosis In addition, R19's d and anxiety. The co- dated 6/16, identifie perception, was a w interviewable and in The care plan direct and investigate per R10's Resident Con- filed by R158 on R ⁻ reported to a staff s down on [R10] show week ago." In the investigation had been intervieware ported "a week ag [NA-E] pushed dow she stood up from 1 told you to sit down The Resolution and sheet indicated bot	viewed regarding the concern e ED stated the concerns was SA, as the investigation was of the facility was made aware, question had been able to ne cares provided. ED stated and unable to give specifics others had been interviewed cerns. ED further stated, "We ed it immediately instead, but irs to investigate." dated 6/17/16, indicated R19 paired cognition and did not s, delusions, or hallucinations. liagnoses included dementia ognitive assessment care plan ed R19 had periods of altered vulnerable adult, was noderate impaired cognition. eted staff to report all concerns policy. ncern Report dated 6/2/16, 10's behalf indicated R158 had seeing a staff person "push ulders in her room about a dated 6/2/16, indicated R158 ed at 4:15 p.m. and had go or so in the dining room vn on [R10's] shoulders when her chair and god dammit I	F 2:	26					

If continuation sheet Page 14 of 82

		AND HUMAN SERVICES				FORM	: 10/17/2016 APPROVED : 0938-0391		
		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DAT	(X3) DATE SURVEY COMPLETED			
		245187	B. WING			09/02/2016			
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE	•			
TEXAS TERRACE CARE CENTER				7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 226 F 254 SS=D	and family member witnessed NA-E or inappropriately. The was at time agitated and staff did try to s the chair unsafely b NA-E denied swear R10's admission M R10 had severely in dementia, and no w displayed. On 9/1/16, at 11:27 displayed extreme stealing his medica unreliable reporter. shift had been calle identified as very in falling. The ED india nursing station, and when R10 stood, N okay. what do you r bathroom?" When a have been reported should have reported to un-substantiate a 483.15(h)(3) CLEA	a.m. the ED stated R10 behaviors, accusing staff of tions, causing a stir and was a The ED indicated staff on the ed in and interviewed. R10 behaviors, accusing staff of tions, causing a stir and was a The ED indicated staff on the ed in and interviewed. R10 was public and at high risk for cated NA-E was behind d resident was behind the table A-E rushed over and said "It's need? Do you need the asked if the allegation should to the SA the ED stated "We ed it first and but we were able abuse in the first 24 hours." N BED/BATH LINENS IN N		226	DEFICIENCY)		10/12/16		
	by:	NT is not met as evidenced tion, interview and document			1. Resident #90 has been provide	d with			

Facility ID: 00144

If continuation sheet Page 15 of 82

	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · /	E SURVEY PLETED	
		245187	B. WING		09/	02/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		02/2010	
TEXAS	ERRACE CARE CEN	ITER		7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 254	review the facility fa sanitary bed linens of 2 resident (R90) incontinence. Findings include: R90's bed was unn sheet with multiple 10:39 a.m. The roc were two fans runn On 8/30/16, at 7:09 When asked about provided, resident a with all his cares, h housekeeping staff room and changing observed with mult p.m. R90's bed was sheet and top sheet were again detected R90's urinary incor catheter Care Area 11/11/15, indicated needs known. R90 dated 1/15, indicated but had a history of On 8/31/16, at 12:1 (LPN)-A stated sheet assist any resident ensure soiled linen there were residen still needed staff out	ailed to ensure clean and were provided as needed for 1 reviewed for urinary nade and the bottom fitted brown smears on 8/29/16, at om had an odor, although there ning at the time. 9 a.m. R90 was in his room. t what assistance staff stated he was independent however, nursing and f assisted him with cleaning the g bedding. The top sheet was iple brown smears. At 12:10 s un-made and both the fitted et had brown smears and odors ed. thinence and indwelling Assessment (CAA) dated the resident was able to make 's bowel elimination care plan ed he was continent of bowel, f constipation and diarrhea. 13 p.m. licensed practical nurse e would have expected staff to who was independent and s were changed. She indicated ts who were independent but	F 25	 4 clean bed linens and bed has be NA-C has been re-educated rechanging of bed linen. 2. Residents will be provided we linen as needed and bed will be a daily basis as residents allow 3. Nursing staff will be provided regarding the provision of clear bed making to residents by 10/4. DON/designee will audit 5 reweek to assure linens are clear is made for 1 month. Continue 5 residents monthly until discon QAPI. Results of audits shared 	garding ith clean e made on r. d education n linen and 12/2016. esidents per n and bed d audits for ntinued by		

If continuation sheet Page 16 of 82

		AND HUMAN SERVICES					FORM	10/17/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	0	(X3) DATI	E SURVEY PLETED
		245187	B. WING				09/	02/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CO	DDE		
TEXAS 1	ERRACE CARE CEN	TER			900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 254 F 279 SS=D	multiple yellow-brownursing assistant (N supposed to chang wait for R90 to be of R90's sheet was sobed. NA-C stated h the previous two da On 9/1/16, at 9:41 a "should change the LPN-C further state his room, but was of approaching to cha explain as the resid On 9/1/16, at 4:25 p stated she would have resident to change On 9/2/16, at 8:00 a requested but was 483.20(d), 483.20(k COMPREHENSIVE A facility must use t to develop, review a comprehensive plan The facility must de plan for each reside objectives and time medical, nursing, an needs that are iden assessment. The care plan must to be furnished to a	wn smears. At 12:30 p.m. NA)-C reported he was e the linen however, had to but of his room. He verified biled and removed it from the e recalled changing the linen ays toward the end of the shift. a.m. LPN-C explained staff, m [linens] in the morning." ed R90 spent a lot of time in cooperative with staff nge the linen. "Staff have to lent is set in his ways." b.m. the director of nursing ave expected NAs to assist their linens as needed. a.m. the linen policy was not provided. ()(1) DEVELOP E CARE PLANS the results of the assessment and revise the resident's		254				10/12/16

If continuation sheet Page 17 of 82

		AND HUMAN SERVICES			FORM	10/17/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		245187	B. WING		09/(02/2016
NAME OF F	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ΤΕΧΔΟ Τ	ERRACE CARE CEN	TEB		7900 WEST 28TH STREET		
			ŝ	SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	§483.25; and any so be required under § due to the resident	eing as required under ervices that would otherwise 483.25 but are not provided s exercise of rights under the right to refuse treatment	F 279			
	This REQUIREMEN by: Based on observat review the facility fa 1 of 2 residents (RS for alcohol intoxicat use illegal substance Findings include: R95's medical reco following: A social service not [social worker] was found in a room roll [cigarettes]. Smokir with resident." A social service not was hosp. for BS du blood sugar due to of the remaining dri done." A communication fo 6/7/16 included R95 emergency room to unresponsiveness a reading. Written in a	NT is not met as evidenced tion, interview and document ailed to develop a careplan for 25) who had been hospitalized ion and had been known to bes in the facility. rd progress notes included the re dated 6/6/16, indicated, "SW informed that resident was ing marijuana as cigs ng/Drugs policy was reviewed re dated 6/7/16 read, "Resident ue to ETOH[hospitalized for alcohol] abuse. SW disposed ink and a room search was		 Resident #95 has a care plan that been reviewed and updated. Upon admission, quarterly, and wisgnificant changes, resdients with of ETOH, or illegal substance use here reviewed and updated, includindividualized interventions are in p The Unit Managers and Social S staff will be provided with education regarding the care planning of substabuse by 10/12/2016. Director of Social Services/desig will audit 3 residents with substance per week to assure care planning is complete and updated for substance for 1 month. Continued audits of 3 residents will continue monthly until discontinued by QAPI. Results of the will be shared at QAPI. 	with history nave ling lace. ervices stance stance e use s ce use	

If continuation sheet Page 18 of 82

		AND HUMAN SERVICES				FORM	: 10/17/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245187	B. WING			09/	02/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	TER			900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 279	Continued From pa last HS [night]."	.ge 18	F 2	279			
	R95 was incoherent blood sugar of 533. was called and prov [immediate] 10 units	ed 6/7/16 at 3:30 p.m. included at and unresponsive with a . R95's nurse practitioner (NP) vided an order for STAT s of Novalog insulin and to ency room for an evaluation.					
	indicated the reside hyperglycemia and	disciplinary team note ent was hospitalized 6/7/16 for alcohol intoxication. R95 later with no new orders.					
	"Resident's care pla reviewed with socia guardian and reside use over the weeke using and reported not to repeat this b	te dated 6/25/16, read an and assessments were al worker, community police, ent. Review of the THC [drug] end. Resident admitted to the source. Resident agreed behavior". A psychology referral the licensed social worker					
	was "seen smoking an illegal substance a trained medication smoking are and sn residents were appr substance was mar apologized to staff f pass it to one anoth nothing found, she 'there is no more.'" nursing were notifie						
		not include the 6/7/16 Ilcohol use or the 6/6/16 and					

If continuation sheet Page 19 of 82

		AND HUMAN SERVICES			FORM	10/17/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY IPLETED
		245187	B. WING		09/	02/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	TER		7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 279 F 280 SS=D	6/25/16 use of mari 7/1/16, revealed the cognitive impairment An interview on 9/1, executive director E clinical services (DC plan did not identify the facility, and that on the careplan. A care plan policy w provided. 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has the incompetent or othe incapacitated under participate in planni changes in care and A comprehensive c within 7 days after t comprehensive asso interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p the resident, the resi legal representative	ijuana. R95's cognitive testing e resident had moderate nt. /16 at 9:14 a.m. with the ED, DON and director of CS) confirmed that the care / R95's alcohol or drug use in t is should have been included was requested but was not 0(k)(2) RIGHT TO NNING CARE-REVISE CP he right, unless adjudged erwise found to be r the laws of the State, to ing care and treatment or	F 279)		10/12/16

Facility ID: 00144

If continuation sheet Page 20 of 82

			000	T 1-			0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION (>		SURVEY
		245187	B. WING			09/02/2016	
NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	TER		7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 280	Continued From pa	-	F 2	280			
	by:	NT is not met as evidenced			1. Resident #95 and resident #177 h		
Based on observation, interview and document review the facility failed to revise care plans to include the need for supervision with smoking for 2 of 7 residents (R95, R117) who required supervision with smoking, and a careplan for 1 of				both been assessed per the smoking assessment/policy to be independent smokers and their care plans reflect status.	t this		
	illegal substances. update and revise t	identified to possess and use In addition, the facility failed to the careplan for weight loss intal status for 1 of 3 (R106) t loss.			2. Residents are assessed on admiss quarterly, and with significant change status their ability to smoke. Care pla will be reviewed and updated accord with the assessment.	e of ans	
	Findings include:				 Staff and residents have been edcuated on facility smoking policy to ensure safety and secured storage o 		
	indicating moderate entrance conference	e assessment dated 7/1/16, e cognitive impairment. During e on 8/29/16, at 8:04 a.m. the 95 required supervision with			smoking materials by residents by 10/12/2016. 4. Director of Social Services/Designee will audit 5 residents whom smoke per week for one month to assure care planning is accurate, smoking		
	R95 as independer careplan dated 7/1	nent dated 3/31/16, identified htly able to smoke. R95's 5, identified R95 smoked, clude if supervision was			assessments are accurate and comp and materials are secured by the res appropriately. Continued audits of 5 residents will continue monthly until discontinued by QAPI. Results of the will be shared at QAPI.	ident	
	smoking on the Ga supervised smoking hours. The surveyo (RN)-A whether the	0 a.m. R95 was observed rden Terrace patio (approved g area) during non-smoking or asked registered nurse e resident was supposed to be io. RN-A replied "no" and into the building.			 5) Resident #118 care plan has been reviewed and updated to indicate a h of marijuana use with measureable g and individualized interventinos for resident safety. 6) Upon admission, quarterly and wit significant changes residents with his 	iistory goals h	
	wheeled outside to	m. R95 independently the front of the facility, sat in and smoked a cigarette, and building.			of chemical dependency will be asse Their care plans for residents with his of illegal substance use have been reviewed to assure if suspicion of	ssed.	

Facility ID: 00144

If continuation sheet Page 21 of 82

	-	AND HUMAN SERVICES			OMB NO.	APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		245187	B. WING _		09/	02/2016
NAME OF	PROVIDER OR SUPPLIER	• •		STREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS 1	ERRACE CARE CEN	TER		7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 280	Continued From pa	age 21	F 28	30		
	On 8/30/16, at 7:24 sitting outside on th smoking a cigarette supervising the sm elevator R95's cloth covered with cigare where the brake of was also filled with Review of R95's main included the followi A social service not informed resident th times for smokers to supervised. Reside and agreed to the r sign out to go indep signs out." A social service not concern is that the remember or comp called guardian who smoke 'only' during as posted on each were informed of th resident comply with A nursing note date indicated R95 was non-smoking hours cigarette that she re An interview with lic on 8/31/16, at 10:42	 a. p.m. R95 was observed to be of Garden Terrace patio b. No staff was observed to be oking. At 7:37 p.m. in the ning and wheelchair were extreme the ashes. There was a hole the wheelchair attached that ash. b. edical record progress notes ng: b. the dated 8/1/16 identified "SW that there will be scheduled to go to the patio to smoke ent signed the smoking policy rules. Resident is also able to be obly with staff requests. SW o agrees to allow resident to supervised scheduled times unit. The resident and staff ne restriction and changehelp 		 substance use is identified; measing goals and individualized intervention place. 7) The Unit Managers and Social staff will be provided with education regarding the care planning of survices by 10/12/2016. 8) Director of Social Services/deare will audit 3 residents with substation per week to assure care planning complete and updated for substation for 1 month. Continued audits of resclients will continue monthly undiscontinued by QAPI. Results of will be shared at QAPI. 9)Resident #106 has been review care plans have been updated for change of dental status, weight los adaptive equipment, and intervet place to ensure measurable goal being met. 10) Care plans are reviewed and upon admission, quarterly and wisignificant changes. The care plaresidents with change of dental status weight loss, and adaptive equipment are oplanned. 11) Unit Managers and Registered Dietician have been educated or plan revisions for changes in der status, adaptive equipment, and loss by 10/12/2016. 12) DON/designee will audit 3 reper week to ensure care plans are reviewed and loss by 10/12/2016. 	tions are I Services ion ibstance signee nce use g is ince use g is ince use antil the audit ved and r his oss, ions in s are updated ith uns for tatus, nent have care ed n care ital weight sidents re	

Facility ID: 00144

If continuation sheet Page 22 of 82

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	E CONSTRUCTION		0938-039 SURVEY
ID PLAN C	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245187	B. WING _			09/	02/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	TER		-	900 WEST 28TH STREET AINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 280	Continued From pa	ge 22	F 2	80			
	should have been le	ocked in the smoking cart.			interventions needed to ensure re		
	An interview with licensed practical nurse (LPN)-C on 8/31/16, at 11:07 a.m. confirmed R95 smoked and required staff supervision and that all smoking materials were to be kept in the smoking cart.			well being. DON/desgnee to audit residents care plans week for one then 3 per month until discontinue QAPI. Results of the audit will be at QAPI.	month d by		
	8:07 a.m. as a resid	by facility staff on 8/29/16, at dent who smoked. A smoking 8/11/16, indicated R177 ked.					
	resident as alert an smoked. Intervention materials were to b	ted 8/15/16, identified the d oriented and someone who ons included smoking e kept in the smoking cart, dicate whether R177 required noking.					
	and stated that he windependently and R177 stated he sign returned as he desired the state of th	red on 8/30/16, at 2:45 p.m. was able to smoke kept his cigarettes in his room. ned out to smoke and left and red. R177 stated he did not go ke because smoke times were					
		p.m. R177 was independently ewalk outside the facility.					
	of RN-A and LSW-0	p.m. R177 was hear inquiring C, why he had "to go outside e suddenwhy now?"					
	about smoking at th	p.m. R177 was interviewed ne facility and stated "I can't go took my cigarettes and I can't					

If continuation sheet Page 23 of 82

		AND HUMAN SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP		(X3) DAT	TE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	à	CON	MPLETED
		245187	B. WING			09	/02/2016
NAME OF F	PROVIDER OR SUPPLIER						
TEXAS T	ERRACE CARE CEN	TER					
(X4) ID		TEMENT OF DEFICIENCIES	ID			-	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)					COMPLETION DATE
F 280	Continued From pa	ge 23	F 2	280)		
	On 9/1/16, at 10:35	a.m. LSW-C was interviewed	DES FORM AI OMB NO. 0 OMB NO. 0 CILA IVER: (22) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE 5 COMPL B. WING B. WING 09/02 STREET ADDRESS, CITY, STATE, ZIP CODE 7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426 09/02 JL ID PREFIX PROVIDERS PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 0 Viewed ON) F 280 F 280 rviewed SW-C Cocked JIS was sion for vare s she jarettes haterials F od e Id have ewed on expect aquired Image: City State Stat				
		oking unsupervised. LSW-C					
		materials were kept locked bassed out the materials was					
	responsible to knov	v who required supervision for					
	0	vas allowed to smoke en asked if she was aware					
	R177 had been kee	eping his own cigarettes she					
		ot that he keeps his cigarettes ned R177's smoking materials					
	had been confiscate						
	On 8/31/16, at 11:0	7 a.m. LPN-B confirmed					
		areplan did not include noking and that it should have					
	been included on th						
		sing (DON) was interviewed on					
		and stated she would expect le if supervision was required					
	for smoking.						
		ace sheet was reviewed and					
		tted to the facility iin 4/16. A ent dated 7/13/16 identified					
		e cognitive impairment.					
		ted 7/16 identified R118 "has					
		ng marijuanastates it's for t's illegal. NP [nurse					
	rractitioner] aware	hold all narcotics if pot					
		ed." The careplan did not further interventions on what					
	to do when in quest						
	The executive direct	ctor, director of nursing (DON)					
	and director of clinic	cal services (DCS) were 16, at 9:14 a.m. and stated					

If continuation sheet Page 24 of 82

PRINTED: 10/17/2016

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	10/17/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		245187	B. WING		09/	02/2016
NAME OF	PROVIDER OR SUPPLIER	•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
TEXAS 1	TERRACE CARE CEN	TER		7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280	R118's careplan wa direct staff to call po search when substa R106's quarterly MI R106 had diagnose disorder. R106 nee independent with ea issues. R106's Nutrition Ris indicated R106 wei prior and the currer The assessment di with interventions to loss. Review of the medi weights were: - 8/30/16, 148 lbs. (- 7/16, no weights a - 6/21/16, 159 lbs. (- 5/16, no weights a - 4/1/16, 167 lbs. The nurse practition 8/8/16, indicated R 26 teeth removed a bleeding secondary warfarin (a blood th hospitalized from 8, bleeding from the to On 8/30/16, at 6:40 on his own, would s stare straight ahead R106 and he drank had pushed half of	as poorly written and did not olice or complete a room ance use was suspected. DS dated 7/16/16, indicated es including anemia and mood eded set up at meals, was ating, and had no weight loss sk Assessment dated 7/27/16, ighed 159 pounds 30 days it weight was not available. id not address the weight loss o reduce the risk of weight ical record indicated the (pounds) available (11 lbs or a 7.4% loss) available (11 lbs or a 7.4% loss) available ner progress note dated 106 had dental surgery, had and had a complication of y to anticoagulant therapy on ninner). Additionally, R106 was /8/16, to 8/11/16 due to ooth extraction.	F 280			

If continuation sheet Page 25 of 82

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	E CONSTRUCTION		E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG .		COM	PLETED
		245187	B. WING _			09/	02/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	TER			900 WEST 28TH STREET		
				5	AINT LOUIS PARK, MN 55426 PROVIDER'S PLAN OF CORRECTION	.1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	Continued From pa	ge 25	F 28	80			
	breakfast, had a two cereal in a bowl and assistance was pro-	a.m. R106 was served o-handled cup with a straw, d a regular plate. No staff vided with eating. The dietary ided plate with raised sides provided for R106.					
	stated cards for eac	a.m. dietary staff (DS)-A ch person with assistive e cart, but were not always					
	have weight loss as R106's tooth extrac include the adaptive	e plan dated 7/21/16, did not a concern and did not identify tions. The care plan did not e equipment for eating, and dependent with eating.					
	on 9/1/16, at 12:20 would be updated b	with the consulting dietitian p.m. she stated the care plan by nursing for oral surgeries. bounds had not been brought					
F 282 SS=E	was requested but	RVICES BY QUALIFIED	F 28	82			10/12/16
	must be provided by	led or arranged by the facility y qualified persons in ch resident's written plan of					
	This REQUIREMEN	NT is not met as evidenced					

If continuation sheet Page 26 of 82

PRINTED: 10/17/2016

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE	0938-039
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		COM	PLETED
		245187	B. WING _			09/0)2/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	TER			900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 282	Based on interview	v and document review, the	F 28	82	1. Resident #101 and #16 have be	en	
	materials was provi (R101, R16) review monitor weights for	ure supervision for smoking ided for 2 of 7 residents ved for accidents and failed to 1 of 3 residents (R16)			assessed per the smokingassessment/policy. Care plans havupdated accordingly.2. Residents are assessed on		
	follow the plan of ca psychotropic medic behavior and ortho	on. In addition, failed failed to are for effective monitoring of cations, including target static blood pressures for 1 of			admission,quarterly, and with signif change of status their ability to smo Care plans have been reviewed an updated to reflect individual interve	oke. d ntions	
	5 residents (R37) reviewed for unnecessary medication use. Findings include:			 related to smoking, security of smo materials, and safety plans. 3. Staff and residents have been educated on facility smoking policy ensure safety and secured storage 	to		
	Smoking R101's diagnoses i	ncluded malignant neoplasm ressive disorder, anxiety,			 smoking materials by residents by 10/12/2016. 4. Director of Social Services/desig will audit 5 residents whom smoke 	nee	
	quadriplegia, musc obtained from the a	le wasting and atrophy admission record dated 4/4/16.			week for one month to assure care planning is accurate, smoking assessments are accurate and con	nplete,	
	5:26 p.m. and at 7: electric wheelchair side walk in front of	6 a.m., 3:07 p.m., 5:08 p.m. to 03 p.m. R101 sat on the with head tilted back at the f the main entrance to the oking with no staff supervising.			and materials are secured by the re appropriately. Continued audits of 5 residents will continue monthly until discontinued by QAPI. Results of th audits will be shared at QAPI.	5	
	smoking policy, ED they had observed 8/30/16, "we talked memo to all resider	p.m. when asked the facility and DON both acknowledged R101 smoking outside on to her and are sending out a nts that they cannot assist			5. Resident #16 weight has been of and nutritional assessment has been completed. The residetns care plan reflective of goals and interventions obtained by these tools.	en 1 is 5	
	responsible for che indicated the facility	moke." When asked who was cking in smoking items both y did not have anyone.			6.Residents' weights are obtained a reviewed monthly or more frequent according to their individual needs. Plans with residents with nutritional	ly Care or	
	4/1/16, indicated re	ssessment care plan dated sident was a dependent be free from serious injury			weight loss risks have been reviewe updated as appropriate.6. Staff has been educated on weig		

Facility ID: 00144

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE	0938-039
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG .		COM	PLETED
		245187	B. WING _			09/0	02/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	ITER			900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 282	Continued From pa	age 27	F 28	82			
	[PCA]" Care plan will be kept at nurs compliance to smo assist with smoking who was responsit smoking when PC/ R101's Smoking St Assessment dated a dependent smok R101's MN Smokin on behalf of reside residents who smo designated smokin smoke and who are smokers will have a (matches, lighters, cigarette, electronit tobacco and/or oth stored in a secure On 9/2/16, at 8:35 stated R101 was a and had the PCA b When asked who s was not at the facil supposed to follow allowed by the facil resident was not at they would be supe	with personal care assistant a directed smoking materials ing station, monitoring king policy and PCA was to g. Care plan did not address ble for assisting R101 with A was not at the facility. afety Data Collection and 4/1/16, indicated resident was er with PCA assisting. ng policy dated 4/1/16, signed nt by PCA directed "3. All ke may only smoke in a ig area. 7. All residents who e assessed to be "Dependent" all their smoking materials other sources of ignition, c cigarettes, cigars, pipes, er inhaled tobacco substitutes) area at the nurses station" a.m. registered nurse (RN)-C supervised dependent smoker ring her outside for smoking. supervised resident when PCA ity RN-C stated resident was the smoking scheduled times lity. RN-C further stated if ole light their own cigarette ervised and another resident to assist with lighting it or			 being obtained, notification of weig and potential care plan intervention specifically related to chagnes in w 7. Staff have been educated on weig and potential care plan intervention specifically related to changees in 8. Director of Nursing/Designee wil 10 resident weights per week to en completion. Director of Nursing/De will audit 3 resident nutritional assessments/care plans per week ensure accuracy and interventions place. Audits will be completed wei 1 month. Then 5 per month until discontinued by QAPI. Audit results shared at QAPI. 9. Resident #37 has been given co for Seroquel, her behaviors have b reviewed, and residents NP has be updated, her othostatic blood press has been obtained. 10. Upon admission, quarterly and significant changes, residents with psychotropic medications will be re and documented on their behavior plan including obtaining consents f psychotropic medication, and ortho blood pressure taken on a monthly 11. Unit Managers, license nurses, the social services department has educated on documenting behavio the behavior care plan, on providin 	ns reight. rights ght loss, ns weight. Il audit isure signee to in ekly for s will be onsent een sure with eviewed care or their ostatic basis. and s been rs on g	
	pulmonary disease disease, diabetes t	cluded chronic obstructive (COPD), peripheral vascular ype II, anxiety, depression, respiratory failure obtained			residents with consent sheets whe utilizing psychotropic medications, monitoring of orthostatic blood pre- by 10/12/2016. 12. Director of Social Services/des	and ssure	

Facility ID: 00144

If continuation sheet Page 28 of 82

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY		
				IG				
		245187	B. WING _			02/2016		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S 7900 WEST 28TH STREE				
TEXAS 1	ERRACE CARE CEN	TER	SAINT LOUIS PARK, MN 55426					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIO DATE		
F 282	the MDS indicated behaviors and had On 8/30/16, at 7:28 smoking in the faci resident was noted approached reside accused of smokin near oxygen. "I fee one else gets watc On 8/31/16, at 6:26 outside on the side (W/C) smoking righ un-supervised. -At 6:45 a.m. surve confirmed resident had a talk with him had gotten smoking "probably from ano -At 6:55 a.m. LPN- supervised smoker smoking policy and working with social facility with in-door -At 7:16 a.m. LPN- resident was consist met on a leave of a out to the street an facility did not have smoking program a	MDS dated 7/8/16. In addition resident did not have severely impaired cognition. B p.m. R16 was observed lity lower level smoking area, with a trach. When nt stated he had been g in his room and smoking I I'm being watched unfairly, no hed." 6 a.m. resident was observed walk seated on his wheelchair nt in front of the building eyor approached DON who was a supervised smoker "I ." When asked where resident g material from DON stated ther resident." C stated resident was a and had violated the facility I the facility was currently service for placement to a smoking room. C approached stated when a dered a supervised smoked it dsence (LOA) they could go d smoke. She indicated the a "per say" supervised and stated she would find out	F 28	to audit 5 resident target behaviors o are documented a of psychotropic me Nursing/designee week to ensure or are completed we	s per week to ensure n behavior care plans ind consistent with goals edications. Director of to audit 5 residents per thostatic blood pressure ekly for 1 month. Then 5 scontinued by QAPI. e shared at QAPI.			
	smoking program a and get back to sur R16's Smoking Sar Assessment dated history of smoking areas. Assessment	and stated she would find out						

If continuation sheet Page 29 of 82

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	10/17/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245187	B. WING _			09/(02/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
TEXAS T	ERRACE CARE CEN	TER			000 WEST 28TH STREET AINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From particular control of the second states of the second sta	age 29 was non-compliant with the re plan assessment dated resident smoked and resident in the room for the second are plan directed "if he has any a time." In addition the care smoking materials would be station. The care plan did not was an independent or even though had been found upplies with him and had n. cluded dysphagia, , tracheostomy status, emia and diabetes type II quarterly MDS dated 7/8/16. In ndicated resident received tube known" for loss of five percent last month or loss of 10% or nths and no weight was oS. 8 p.m. R16's was observed the lower level designated was noted with a trach. R16 for and stated he had resided since this last winter. "I have a apist won't let me eat, I'm on a and drink when i get a chance. It o get me in for a swallow had aspiration pneumonia and	F 28	82			
	During document re	eview it was revealed:					

If continuation sheet Page 30 of 82

STATEMENT	OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DAT	0938-039 E SURVEY PLETED	
		245187	B. WING			09/	02/2016	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
TEXAS 1	ERRACE CARE CEN	ITER			900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE	
F 282	-R16 had no condi may result in a life months -Was not on a plar -Had a 18 pounds closest weight to s re-admission weig loss. -Vital Signs-Individ revealed no weigh documented on ac -4/2/16, weight wa -4/16, weight wa -4/11/16, weight wa -4/11/16, weight wa -4/11/16, weight wa -4/11/16, refused wa -8/30/16, weight wa surveyor requested R16's nutrition card resident had a nutr disease, was at ris diabetes type II. Ca remain stable +/-3° provide diet as ord supplements was a needed (PRN) per The nutrition progr indicated R16 was tube feeding tolera Nutrition note date was not meeting th hydration seconda himself from the tu day to smoke and	tion or chronic disease that expectancy of less than 6 aned weight loss program (lbs) weight loss between the survey and most recent ht which was a 9.7% weight lual Resident Flowsheet ts had been obtained or lmit 11/18/16, through 4/1/16. s 199.8 lbs s 202.0 lbs as 202.6 lbs ghts obtained eight as 185.6 lbs obtained after d R16 to be weighted. e plan dated 4/4/16, indicated ritional risk related to cardiac ck for dehydration secondary to are plan goal "weight will %." Care plan directed staff to lered, nothing by mouth (NPO), ordered and monitor weights as	F 2	282				

If continuation sheet Page 31 of 82

		AND HUMAN SERVICES				FORM	: 10/17/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245187	B. WING			09/	02/2016
NAME OF	PROVIDER OR SUPPLIER		· [S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS 1	ERRACE CARE CEN	TER		79	900 WEST 28TH STREET		
TEXAO				S	AINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	Continued From pa	lge 31	F 2	82			
	resident had dysph mouth and received On 8/30/16, at 11:4 dietician (CRD) ack struggle getting res surveyors brought t missing weights in records. CRD state without weights and were not obtained of -At 11:42 a.m. CRD we had to be switch started at the facilit she had been send issues weekly to co director (ED) and d included on about t honest I need other board so we can ge acknowledged the	0 a.m. consultant registered knowledged it had been a idents weighed when to her attention the multiple several residents medical ed she was doing assessments d had to document weights					
	if resident weight w monthly CRD state it." CRD acknowled monitoring resident (TF) was learning the between two facilities had noticed the miss and went along to a back to it and over -When asked if R10 CRD stated she wo	o.m. CRD stated When asked as supposed to be monitored d "I would like to keep up with lged the hindrance to as who received tube feeding he new role and balancing es. CRD stated she probably using weights at the moment another chart and never got time failed through the crack. 6 had sustained a weight loss buld consider a weight loss and have been notified of the					

Facility ID: 00144

If continuation sheet Page 32 of 82

		AND HUMAN SERVICES				FORM	10/17/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245187	B. WING _			09/	02/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
TEXAS T	ERRACE CARE CEN	TER		-	000 WEST 28TH STREET AINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	Continued From pa weight loss betwee weights. CRD state who wrote it to have stated R16 was at a would re-evaluate of had identified the 9 On 9/1/16, at 4:10 p (NP) stated she wo monitor R16's weig risk for nutrition. NF call from one of the indicating R16's tub and she had to give NP stated prior to g order she had requi- but was told CRD h further stated she h resident not being s of resident diabetes was at a high risk for Unnecessary medic R37 diagnoses incl brain injury and seiz the quarterly MDS of MDS indicated R37 had severely impain R37's physician oro following orders: -Quetiapine Fumara 25 mg by mouth tw behavioral disturba	ge 32 n 4/11/16, and 8/30/16, d she would expect the nurse e updated her. CRD further a high risk for malnutrition and current interventions since she .7% weight loss. 0.m. the nurse practitioner uld have expected the CRD to hts close due to R16's high P stated she had received a nurses at the facility be feeding brand had run out e an order for a different brand. iving the recent tube feeding ested R16 to be seen by CRD had not seen R16 yet. NP had received reports of seen by the CRD and because and refusing tube feeding br nutrition. cation uded dementia, traumatic zure disorder obtained from dated 8/6/16. In addition the did not any behaviors and red cognition. der dated 6/6/16, revealed the ate (Seroquel-antipsychotic) ice daily for dementia with nces epressant) 150 mg by mouth at	F 2	82	DEFICIENCY)		
	bedtime for depres						

If continuation sheet Page 33 of 82

		AND HUMAN SERVICES				FORM	: 10/17/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245187	B. WING			09/	/02/2016
	PROVIDER OR SUPPLIER	TER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426	<u>.</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 282	indicated resident u In addition the CAA potential for advers and directed to revi interventions. R37's care plan for assessment dated had potential for sic psychotropic drug u R37 used Trazodor Seroquel for trauma cognitive decline. T monitor for hypoten pressure and behav deterioration. On 8/31/16, at 12:2 the behavior of curs punch anybody. Sh resident had cursed an hour or so she w asked about R37's had a good support phone to talk with fa resident was depre On 9/1/16, at 6:45 a never had any phys kicking or harming aware in the facility was very verbally a depended on if she On 9/1/16, at 9:31 a verified resident cha consent for medica behavior monitoring	used Seroquel and Trazodone. A indicated resident had be effects from medications whe care plan for mood and behavior symptoms 11/10/15, indicated resident de effects related to use. The care plan identified he for depression and atic brain injury (TBI) with the care plan directed staff to hsion, orthostatic blood vior and cognitive impairment as p.m. LPN-A stated R37 had sing out but did not hit, kick, e indicated overall after d out if staff approached her in would be pleasant. When mood LPN-A stated resident t system and would use the amily and did not think	F2	282			

If continuation sheet Page 34 of 82

		AND HUMAN SERVICES				FORM	10/17/2016 APPROVED 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245187	B. WING			09/02/2016		
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
TEXAS T	ERRACE CARE CEN	TER			900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 282	supposed to be dor psychotropic medic On 9/1/16, at 10:06 (LSW)-A acknowled not been completed LSW-A stated the s only at one occasio had not been anybo documentation to m monitoring was bein the social services of positions which wour review for document forward. On 9/1/16, at 4:09 p would expect facility tracking and trendin psychosis and had medication was bet well being. NP furth expected the facility pressure for a resid as that was a facility potential for orthosi and Trazodone. On 9/1/16, at 4:24 p would have expected monitored and orthoc checked monthly as checked monthly.	e last three months "they are he at least once a month for lation use." a.m. licensed social worker dged behavior monitoring had d for R37 for the last 90 days. taff had documented behavior n. LSW-A acknowledged there bdy looking at the staff hake sure the behavior ng done. LSW-A further stated department had just filled the uld help to closely audit and tation of behavior moving b.m. R37's NP stated she y was completing behavior ng as resident had occasional discussed with the family the ter for resident comfort and her stated she would have y to monitor orthostatic blood lent on antipsychotropic meds y protocol she thought and the s as a side effect of Seroquel b.m. the DON stated she ed the behaviors to be ostatic blood pressures to be s that was supposed to be	F2	282				
F 309	requested but was 483.25 PROVIDE C	never provided. CARE/SERVICES FOR	FS	309			10/12/16	

Facility ID: 00144

If continuation sheet Page 35 of 82

					FORM	10/17/2016 APPROVED 0938-0391
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	245187	B. WING			09/0	02/2016
PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ERRACE CARE CEN	TER					
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
	-	F:	309			
provide the necess or maintain the high mental, and psycho	ary care and services to attain nest practicable physical, psocial well-being, in					
by: Based on observat review, the facility fa management was p reviewed for pain. Findings include: R16's diagnoses inc disease, diabetes, a schizophrenia obtai Minimum Data Set R16's pain Care Are 4/18/16, identified r pain interfered with staff was aware and appropriately as ord resident comfortabl R16's pain assess resident did not hav pain and R16 denie R16's physician ord the resident had the	tion, interview and document ailed to ensure effective pain place for 1 of 4 residents (R16) cluded peripheral vascular anxiety, depression, and ned from the quarterly (MDS) dated 7/8/16. ea Assessment (CAA) dated esident had pain and indicated sleep. The CAA indicated d offered medications dered to manage and keep e. ment dated 7/1/16, indicated ve any signs and symptoms of ed any pain. lers dated 8/16/16, indicated e following orders for pain			 pain and expresses that he does not any changes made to his pain regim NP has been updated with results or assessment and frequency of pain medication use. Care plans have be reviewed and updated accordingly. Residnets are assessed for pain admission, quarterly, and with signif changes. Residents receiving PRN medication have been assessed for effectiveness of medication regimer NP's/MD's have been updated on frequent PRN use and care plans up accordingly. Nurses have been re-edcuated or use of pain medication of frequent or ineffective pain management by 10/12/2016. DON/designee will audit 5 resider receiving PRN pain medication ween 1 month to ensure residents pain medication program is effective, not 	ot want nen. of een upon ficant pain n. pdated n the ation ns and ekly for n	
	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER ERRACE CARE CEN SUMMARY STA (EACH DEFICIENCY REGULATORY OR LA Continued From pa HIGHEST WELL B Each resident must provide the necessa or maintain the high mental, and psycho accordance with the and plan of care. This REQUIREMEN by: Based on observat review, the facility fa management was p reviewed for pain. Findings include: R16's diagnoses ind disease, diabetes, a schizophrenia obtai Minimum Data Set R16's pain Care Ard 4/18/16, identified r pain interfered with staff was aware and appropriately as ord resident comfortabl R16's pain assessor resident did not hav pain and R16 denie R16's physician ord the resident had the	DF CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 245187 PROVIDER OR SUPPLIER ERRACE CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 35 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure effective pain management was place for 1 of 4 residents (R16) reviewed for pain.	AS FOR MEDICARE & MEDICAID SERVICES Image: Construction of the provide of th	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER: (X2) MULTIPL A. BUILDING. 245187 B. WING PROVIDER OR SUPPLIER 245187 ERRACE CARE CENTER 74 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 35 HIGHEST WELL BEING F 309 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure effective pain management was place for 1 of 4 residents (R16) reviewed for pain. Findings include: R16's diagnoses included peripheral vascular disease, diabetes, anxiety, depression, and schizophrenia obtained from the quarterly Minimum Data Set (MDS) dated 7/8/16. R16's pain Care Area Assessment (CAA) dated 4/18/16, identified resident had pain and indicated pain interfered with sleep. The CAA indicated staff was aware and offered medications appropriately as ordered to manage and keep resident comfortable. R16's pain assessment dated 7/1/16, indicated resident did not have any signs and symptoms of pain and R16 denied any pain. R16's physician orders dated 8/16/16, indicated the resident had the following orders for pain <td>IMENT OF HEALTH AND HUMAN SERVICES ON SF OR MEDICARE & MEDICAID SERVICES ON OF ORRECTION (X1) PROVIDERSUPPLER/LIA DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION PROVIDER OR SUPPLIER 245187 INVING ERRACE CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE REACH CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMANY STATEMENT OF DEFICIENCIES (EACH DERICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PD REGULATORY OR LSC DENTIFYING INFORMATION) PRETX TAG PROVIDER SPACE TO THE APPROPT Continued From page 35 HIGHEST WELL BEING F 309 Interview, the facility failed to ensure affective pain management was place for 1 of 4 residents (R16) reviewed for pain. F 309 This REQUIREMENT is not met as evidenced by: Street ADDRESS, CITY, and With signin regin medication use. Care plans have be reviewed and updated with results casessent and frequency of pain medication use. Care plans have be reviewed and updated with results casesses for pain admission, quaterly, and with signin PRIV NP has been updated with results casesses for pain admission, quaterly, and with signin PRIV Nerviewed and updated and regiment by resident comfortable. R16's pain Care Area Assessment (CAA) dated resident comfortable. NURS have been re-eduated of regiment comfortable. R16's pain assessment date 71/16, indicated resident comfortable. Nurses have been re-eduated of receiving</td> <td>MENT OF HEALTH AND HUMAN SERVICES FORM. SF COR MEDICARE & MEDICAID SERVICES OMB NO. or operocensories (x1) PROVIDERSUPPLEMCLIA IDENTIFICATION NUMBER (x2) MULTIPLE CONSTRUCTION A. BUILDING (x3) DATE PROVIDER OR SUPPLER 245187 B. WING 03// PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 03// PROVIDER PAREMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTFINING INFORMATION) D PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SPALID REGULATORY OR LSC DENTFINING INFORMATION) D Continued From page 35 HIGHEST WELL BEING F 309 I. Resident #16 has been reassessed for pain and expresses that he does not want any changes made to his pain regimen. This REQUIREMENT is not met as evidenced by: F 309 1. Resident #16 has been reassessed for pain and expresses that he does not want any changes made to his pain regimen. This REQUIREMENT is not met as evidenced by: NP has been updated accordingly. 2. Residents are assessed for pain and expresses that he does not want any changes made to his pain regimen. R16's diagnoses included peripheral vascular disease, diabetes, anxiely, depression, and schizophrenia obtained from the quarterly Minimum Data Set (MDS) dated 7/8/16. NP s/MD's have been updated on frequent PRN use and care plans updated accordingly. Nerweed and updated accordingly. Nerweed and updated accordingly. <</td>	IMENT OF HEALTH AND HUMAN SERVICES ON SF OR MEDICARE & MEDICAID SERVICES ON OF ORRECTION (X1) PROVIDERSUPPLER/LIA DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION PROVIDER OR SUPPLIER 245187 INVING ERRACE CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE REACH CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMANY STATEMENT OF DEFICIENCIES (EACH DERICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PD REGULATORY OR LSC DENTIFYING INFORMATION) PRETX TAG PROVIDER SPACE TO THE APPROPT Continued From page 35 HIGHEST WELL BEING F 309 Interview, the facility failed to ensure affective pain management was place for 1 of 4 residents (R16) reviewed for pain. F 309 This REQUIREMENT is not met as evidenced by: Street ADDRESS, CITY, and With signin regin medication use. Care plans have be reviewed and updated with results casessent and frequency of pain medication use. Care plans have be reviewed and updated with results casesses for pain admission, quaterly, and with signin PRIV NP has been updated with results casesses for pain admission, quaterly, and with signin PRIV Nerviewed and updated and regiment by resident comfortable. R16's pain Care Area Assessment (CAA) dated resident comfortable. NURS have been re-eduated of regiment comfortable. R16's pain assessment date 71/16, indicated resident comfortable. Nurses have been re-eduated of receiving	MENT OF HEALTH AND HUMAN SERVICES FORM. SF COR MEDICARE & MEDICAID SERVICES OMB NO. or operocensories (x1) PROVIDERSUPPLEMCLIA IDENTIFICATION NUMBER (x2) MULTIPLE CONSTRUCTION A. BUILDING (x3) DATE PROVIDER OR SUPPLER 245187 B. WING 03// PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 03// PROVIDER PAREMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTFINING INFORMATION) D PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SPALID REGULATORY OR LSC DENTFINING INFORMATION) D Continued From page 35 HIGHEST WELL BEING F 309 I. Resident #16 has been reassessed for pain and expresses that he does not want any changes made to his pain regimen. This REQUIREMENT is not met as evidenced by: F 309 1. Resident #16 has been reassessed for pain and expresses that he does not want any changes made to his pain regimen. This REQUIREMENT is not met as evidenced by: NP has been updated accordingly. 2. Residents are assessed for pain and expresses that he does not want any changes made to his pain regimen. R16's diagnoses included peripheral vascular disease, diabetes, anxiely, depression, and schizophrenia obtained from the quarterly Minimum Data Set (MDS) dated 7/8/16. NP s/MD's have been updated on frequent PRN use and care plans updated accordingly. Nerweed and updated accordingly. Nerweed and updated accordingly. <

Facility ID: 00144

If continuation sheet Page 36 of 82

		AND HUMAN SERVICES				FORM	10/17/2016 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED	
		245187	B. WING			09/02/2016		
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
TEXAS 1	ERRACE CARE CEN	TER			900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309	(mg) 1 tablet by mo (G-tube) every 12 h pain not relieved wi moderate pain), Ac milliliter (ml) (650 n hours as needed. F pain medications. On 8/30/16, at 12:0 pain in both legs. R anymore at this tim On 9/1/16, at 10:48 well and did not hay stated he was able gave him strong pa him most of the tim R16's pain manage indicated the reside alteration in comfor diabetes. The goal when questioned." administer pain me and record effective medications as nee verbal signs and sy heat/cold packs an pain management regimen with provid During review of the records (MARs) the - 6/16, R16 was no mg 13 times this m evidence of the effi non-pharmacologic	bain medication) 4 milligram buth/via gastrostomy tube hours as needed (PRN) for ith Tylenol (for mild to retaminophen cherry 20.3 ng) via feeding tube every four R16 had no regularly scheduled 03 p.m. R16 reported he had R16 did not want to talk e. 8 a.m. R16 stated he had slept ve any pain at the time. R16 to verbalize pain and staff in medications that staff gave re. 9 ment care plan dated 4/1/16, ent had a potential for t related to pain secondary to was "No complaints of pain The care plan directed staff to redications as ordered, monitor eness and side effects of eded, assess for verbal and not rmptoms of distress, provide d discuss concerns regarding and review medication		309	used, and the pain flow sheet is bei utilized. Continued audits of 5 resid- will continue monthly until discontine QAPI. Results of the audit will be sh at QAPI.	ents ued by		

PRINTED: 10/17/2016 FORM APPROVED

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 10/17/2016 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		245187	B. WING			09 /	/02/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS	TERRACE CARE CEN	TER			/900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	administered the m -7/16, R16 was not times in July. Howe documentation of th or non-pharmacolo Document review ir administered the m -8/16, R16 was not times this month. H consistent documen medication or non-p attempted. Review Tylenol was not pro During further revie notes, from 6/1/16, consistent documen non-pharmacologic medication, and if t on the increased pa narcotics. On 9/1/16, at 2:01 p (LPN)-C stated she call the nurse pract so pain medications since R16 was rece frequently. LPN-C a the nurses to docur interventions prior t as well as the effica was given. LPN-C s assessment should the pain assessment pain. However, R16 and received PRN	p.m. licensed practical nurse would expect the nurse's to itioner (NP) or primary doctor s could be routinely provided eiving the PRN Dilaudid more also stated she would expect med to receive a sub- nation of the efficacy of the pharmacological interventions of documents revealed ovided the month of 8/16.	F	309			

Facility ID: 00144

If continuation sheet Page 38 of 82

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/17/2016 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED		
		245187	B. WING			09/(02/2016		
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE				
TEXAS T	ERRACE CARE CEN	TER		7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 309 F 323 SS=E	The NP thought the seen R16 recently of increased pain had physician. The NP s nurses to document interventions before as well as the efficat used. Review of NF was no documentation of 9/1/16, at 4:22 p (DON) stated she we document non-phare before PRN pain meeffectiveness and to NP on increased us 483.25(h) FREE OF HAZARDS/SUPER? The facility must enervironment remaint as is possible; and a adequate supervision prevent accidents. This REQUIREMENT by: Based on observatt review, the facility fat was provided to min related to alcohol (Eresidents (R95, R11 related to smoking to the second sec	nd increased reports of pain. primary doctor (MD) had on 8/29/16, however the not been reported to the stated she would expect the t non-pharmacological the PRN pain medication use acy of the pain medication if and MD notes revealed there tion of a pain review.		309	 Resident #95 and #118 have had care plan reviewed, updated, and interventions have been added to en- residents safety and highest practic being. Residents with a history of substata abuse will be reviewed for safety and 	nsure al well	10/12/16		

Facility ID: 00144

If continuation sheet Page 39 of 82

		AND HUMAN SERVICES				FORM	10/17/2016 APPROVED 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		245187	B. WING			09/0	02/2016	
NAME OF F	PROVIDER OR SUPPLIER		-		TREET ADDRESS, CITY, STATE, ZIP CODE 900 WEST 28TH STREET			
TEXAS T	ERRACE CARE CEN	TER						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 323	Continued From pa	age 39	FS	323				
	Findings include:				supervision upon admission, quar with significant changes. Resident	s who		
	R95's medical record progress notes included the following:				have a history of substance abuse been identified and care plan inter have been added to ensure reside safety and highest practical well b	ventions ent		
	[social worker] was found in a room rol	te dated 6/6/16, indicated, "SW informed that resident was ling marijuana as cigs ng/Drugs policy was reviewed			 Staff have been re-educated or ETOH/drug use plan and expecta follow up if residents are suspecte using either substance by 10/12/2 DSS/designee will audit 3 resid care plans per week for one mont 	facility ions for d of 016. ents		
	was hosp. for BS d blood sugar due to	te dated 6/7/16 read, "Resident ue to ETOH[hospitalized for alcohol] abuse. SW disposed ink and a room search was			ensure interventions are in place t promote well being and safety of residents. NHA/designee will audi members per week for one month ensure understanding of policy/ste take if ETOH/drug use is suspected	o 5 staff to eps to		
	6/7/16 included R9 emergency room to unresponsiveness reading. Written in	orm and progress note dated 5 was sent to the hospital o evaluate and treat and an elevated blood sugar above the R95's name ing "[R95] was smoking pot			any residents. After one month au continue for 3 care plans per mon interviews per month until disconti QAPI. Results of audits will be dis at QAPI.	dits will th and 5 nued by		
	last HS [night]."				5. Resident #95, #177, and #16 ha			
	R95 was incoheren blood sugar of 533 was called and pro [immediate] 10 unit	ed 6/7/16 at 3:30 p.m. included at and unresponsive with a . R95's nurse practitioner (NP) vided an order for STAT ts of Novalog insulin and to ency room for an evaluation.			 assessment/policy to be independ smokers. Resident #101 has beer assessed per smoking assessment to be a dependent smoker. 6. Residents who smoke will be rupon admission, quarterly, and sig observed. Besidents who surrently. 	nt/policy eviewed Inificant		
	indicated the reside hyperglycemia and	disciplinary team note ent was hospitalized 6/7/16, for alcohol intoxication. R95 later with no new orders.			changes. Residents who currently have been reviewed and individua interventions have been put in pla promote resident well being as ne 7. Staff has been edcuated on fac smoking policy, indivdualized	lized ce to eded. ility		
	A social service not	te dated 6/25/16, read			interventions, and system in place	to		

Facility ID: 00144

If continuation sheet Page 40 of 82

STATEMENT	OF DEFICIENCIES	KEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	0. 0938-039			
IND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	COr	MPLETED			
		245187	B. WING _			/02/2016			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE				
TEXAS	ERRACE CARE CEN	ITER		7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE			
F 323	"Resident's care pl reviewed with socia guardian and resid use over the week using and reported not to repeat this b was also set up by (LSW). A nursing noted da was "seen smoking an illegal substanc a trained medicatic smoking are and s residents were app substance was ma apologized to staff pass it to one anot nothing found, she 'there is no more."" nursing were notifie A patient care visit dated 6/15/16, ider ER visit with alcohe reported several of caught with marijua portion of the patie indicated an "abso discussed with pati R95's face sheet w was admitted to the diagnoses includin and Hepatitis C. An interview with L	an and assessments were al worker, community police, ent. Review of the THC [drug] end. Resident admitted to the source. Resident agreed behavior". A psychology referral the licensed social worker ted 6/26/16 at 3:00 p.m. R95 g with another resident [R118] e. The nurse accompanied by on aide came out to the melled the substance. The proached and asked if the rijuana. The residents for smoking it but continued to her. [R95] was searched and had no pockets and stated, R95's NP and the director of ed. note made by R95's physician ntified "substance abuse-recent of use and nursing staff have ccasions where she has been ana." In the assessment/plan nt care visit note the physician lute need to avoid ETOH	F 32	23 monitor smoking materi are stored securely by 1 8. Director of Social Ser will audit 5 residents per smoking assessments a up to date. NHA/designe members per week to e understanding of smokin expectation of supervisi materials. Audits will be for 1 month, then 5 per discontinued by QAPI. F be shared at QAPI.	0/12/2016. vices/Designee week to ensure are accurate and ee will audit 5 staff nsure ng policy and on of smoking performed weekly month until				

If continuation sheet Page 41 of 82

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	10/17/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245187	B. WING _			09/	02/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS 1	FERRACE CARE CEN	TER			900 WEST 28TH STREET AINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	another resident (R how he became aw marijuana use but a report or the 24-hou An interview with lic (LPN)-C on 8/31/16 was aware of R95's alcohol intoxication notes were not four LPN-C confirmed h should have been i LPN-C was "not su alcohol. LPN-C stat R95's marijuana use R95 obtained the m resident. LPN-C we documented use of the DON executive LPN-C stated altho and marijuana use careplan. There wa intervention if R95 was sugar levels, alcoho mental status. R118's admission f indicated R118 adm diagnoses including A nursing note date indicated R118 was substance with with Garden terrace nur	A118). LSW-A could not recall vare of the alcohol use or assumed it was from staff ur board. censed practical nurse 5 at 11:07 a.m. confirmed she s 6/7/16 hospitalization for h, however the related hospital and in R95's medical record. nospitalizatino information ncluded in the medical record. re" how R95 had obtained ted she was also aware of se with R118, and assumed harijuana from the other ent on to say staff should have f alcohol or marijuana, called director, and the police. bugh staff was aware, alcohol were not included on R95's as no direction for staff was using those substances. d from the 6/7/16, emergency uested and provided which treated for elevated blood ol intoxication and altered	F 3	23			

If continuation sheet Page 42 of 82

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 10/17/2016 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		245187	B. WING			09/	/02/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS 1	FERRACE CARE CEN	TER			900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	smelled marijuana a When asked about stated it was mariju for smoking, but co another. R118 state had. There is nothin practitioner (NP) wa R118's careplan da been caught smokin pain reliefknows it narcotics if pot susp careplan did not ide for staff if R118 was illegal substances. R118's pain data co dated 7/11/16, indio pelvic fracture pain non-pharmacologic effectiveness): "sm potknows its illega A cognitive assess R118 had moderate interdisciplinary tea indicated R118 repo to relieve chronic pain narcotic pain medio marijiuana. The ED, DON, and (DCS) were intervite and stated they were use, but were unaw R95. They confirme doucmented incider expected to be info	and approached the residents. the substance the residents uana. They apologized to staff ontinued to pass it to one ed "We only smoked what I ng else I promise." The nurse as updated. tted 7/16, identified R118 "has ing marijuanastates it's for t's illegal. NP awarehold all pected/witnessed." The entify any further interventions s using or suspected of using ollection and assessment cated R118 had a history of and listed under cal approaches tried (and toking, repositioning, al". ment dated 7/13/16, identified	F 3	323			

If continuation sheet Page 43 of 82

		AND HUMAN SERVICES				FORM	: 10/17/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245187	B. WING	i		09/	02/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS 1	ERRACE CARE CEN	TER			7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	careplan was "poor staff to call the polic when substance us stated that staff was marijuana protocol, marijuana protocol provided a PowerP slide entitled "Finar staff for alcohol use [nursing assistants/ confront resident, s NP, conduct room s document in reside board!!! use the 24 NOTES! CALL DOI (sex, money, alcoho Act] standards and A follow up interview services (DCS) on the nurse document 6/26/16, was not ac between R118 and "The nurse wasn't of document what had but she didn't docum statement. We sho documented itOb and they needed a document it. When how the residents w there was exposure DCS replied "I didr Smoking: R95 had a cognition indicating moderate entrance conference	age 43 dy written" and did not direct ce or complete a room search as was suspected. The DON s educated on a facility , however a copy of the was not provided. The ED oint presentation with one ncial's/ETOH" that directed e to do the following: "NARS fregistered] notify nurse, smell breath/look for signs, call search and confiscate alcohol, nt chart, document on 24 hour hour board to all updates. NO N! CALL ADMINISTRATOR! ol, etc.), EJA [Elder Justice reporting requirements." w with the director of clinical 9/1/16, at 1:45 p.m. revealed ating the progress note of ctually a witness to the event R95. The DCS explained, butside so she couldn't d happened. The NA was there ment it. We had her write a uld've investigated and viously it's a systems issue" system to thoroughly asked if the facility considered vere obtaining drugs and if e to contagious diseases, the n't even think of that."	F	323	3		

Facility ID: 00144

If continuation sheet Page 44 of 82

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	10/17/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245187	B. WING		09/02/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	TER		7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	Continued From pa	age 44	F 323	3		
	R95 as an independent dated 7/15, identified	ment dated 3/31/16, identified Ident smoker. R95's careplan ed R95 was a smoker, clude R95 required supervision				
	smoking on the Ga supervised smoking hours. The surveyo (RN)-A if R95 was s	00 a.m. R95 was observed arden Terrace patio (approved g area) during non-smoking or asked registered nurse supposed to be smoking on a stated "no" and went out to to the building.				
	wheel herself outsid sat in front of the m	.m. R95 was observed to de to the front of the facility, nailbox and smoked a n wheeled herself back into the				
	sitting outside on the smoking a cigarette supervising the smo assistance of the su she was unable to g the smoking area. S R95 back into the fa observed on the pa 7:37 p.m. in the ele wheelchair were ob cigarette ashes. Th	4 p.m. R95 was observed ne Garden Terrace patio e. No staff was observed to be oking. R95 requested urveyor to get back into facility, get back up the sidewalk from Staff was obtained to assist facility. A coffee can was atio to dispose of cigarettes. At evator R95's clothing and observed to be covered with here was a hole where the chair attached that was also				
	Review of R95's me included the followi	edical record progress notes ing:				

If continuation sheet Page 45 of 82

		AND HUMAN SERVICES				FORM	10/17/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245187	B. WING			09/(02/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	TER			900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	A social service not informed resident th times for smokers t supervised. Reside and agreed to the m sign out to go indep signs out." A social service not informed that staff h the facility, signed of report that resident herself backwards i possibility of falling resident has been m The concern is that remember or comp called guardian who smoke "only" during as posted on each were informed of th resident comply wit A nursing note date indicated R95 was non-smoking hours were informed and of violating the new other residents bec disrespectful. R95 s she received from a Interview with SW-A confirmed R95 was supervised on the p her smoking materi smoking cart. SW-A	te dated 8/1/16 identified "SW hat there will be scheduled to go to the patio to smoke ent signed the smoking policy ules. Resident is also able to bendently to smoke if she te dated 8/2/16 noted "SW was has witnessed resident outside but for smoking. The staff has been seen pushing in her chair, unaware of the off the curb or sidewalk. The redirected twice not to do this. It he resident is unable to bly with staff requests. SW o agrees to allow resident to g supervised scheduled times unit. The resident and staff he restriction and change-help th change." ed 8/6/16, at 10:30 p.m. observed smoking during advised of the consequence of the consequence of the consequence of the another cigarette that	F3	323			

If continuation sheet Page 46 of 82

		AND HUMAN SERVICES				F	ORM A	10/17/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		(3) DATE	E SURVEY PLETED
		245187	B. WING	i		09/02/2016		
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
TEXAS T	ERRACE CARE CEN	TER			7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE		(X5) COMPLETION DATE
F 323	Interview with licens on 8/31/16, at 11:07 smoker who require smoking materials of cart. LPN-C stated smoking during the R177's face sheet i the facility of 8/9/16 chronic obstructive anxiety, and hyperte conference with the a.m. R177 was ider required supervision A smoking assessin R177 was an indep R177's careplan da as alert and oriente included R177's sm in the smoking cart required supervision R177 was interview stated that he was a kept his cigarettes i was able to sign ou back when he want go to the patio to sm times to smoke. On 8/30/16, at 8:14 the sidewalk outsid smoking. It was da standing smoking of residents (R39, R1 ⁻ supervision. No rec	sed practical nurse (LPN)-C 7 a.m. confirmed R95 was a ed staff supervision and that all would be kept in the smoking nursing assistants supervised posted times. included an admission date to and included diagnoses of pulmonary disease (COPD), ension. Upon entrance e facility on 8/29/16, at 8:07 ntified as a smoker who in with smoking. nent dated 8/11/16, indicated bendent smoker. ated 8/15/16, identified R177 ed and a smoker. The careplan noking materials would be kept but failed to identify R177		323				

If continuation sheet Page 47 of 82

		AND HUMAN SERVICES				FORM	: 10/17/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245187	B. WING			09/	/02/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS 1	ERRACE CARE CEN	TER					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	residents were obsectigarettes on the side "ashing" her cigaret cup. On 8/30/16, at 7:07 residents were assect their own, unsupervert front desk, got ciga and could leave the smoking on the pat from the smoking c cigarettes or lighter On 8/31/16, at 1:35 inquiring why he ha of the sudden, why RN-A and SW-C. On 8/31/16, at 3:03 about smoking at th outside here, they t go outside." On 9/1/16, at 10:35 regarding R177 sm stated that smoking up and whomever p responsible to know smoking and who w independently. Whe R177 had been kee replied "I don't dout on him" and confirm were confiscated on R101's diagnoses in of brain, major deputation	erved putting out their dewalk. R39 was observed tte into a Styrofoam coffee 7 p.m. LPN-C stated if essed as safe to smoke on vised, they signed out at the rettes from the smoking cart a facility. If people were to they should get cigarettes eart. No one should have to a so on them. 6 p.m. R177 was observed d "to go outside supervised all now?" when speaking with 6 p.m. R177 was interviewed he facility and stated "I can't go took my cigarettes and I can't to a.m. SW-C was interviewed oking unsupervised. SW-C g materials were kept locked bassed out the materials was who required supervision for vas allowed to smoke en asked if she was aware eping his own cigarettes she of that he keeps his cigarettes ned R177's smoking materials n 8/31/16. ncluded malignant neoplasm ressive disorder, anxiety, le wasting and atrophy based	F3	323			

If continuation sheet Page 48 of 82

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES	T			DMB NO. 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY IPLETED
		245187	B. WING	B. WING			02/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
TEXAS T	ERRACE CARE CEN	TER			900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIZ TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)		COMPLÉTION DATE
F 323	Continued From pa	ige 48	F 3	23			
	wheelchair with hea on the side walk in	6 a.m. R101 sat in the electric ad tilted back. R101 was sitting front of the main entrance to without staff supervision.					
	her electric wheelch across the therapy entrance. R101 was back in the wheelch family member was	7 p.m. R101 was observed in hair parked by the stop sign entrance by the facility main s smoking independently tilted hair. At 3:10 p.m. R101's s observed walk out of the ce toward the side walk as smoke.					
	was observed smol	:08 p.m. to 5:26 p.m. R101 king unsupervised on the side building with two other					
	wheel out of the fact walk in front of the lin her mouth. At 7:0 stood or sat on their p.m. R101 remainer smoke un-supervise three other resident the side walk. R51 another resident her mouth. At 7:45 p.m (LSW)-B approacher the residents. At 7:4 wheel into the build	C C					
	residents were asset their own (unsuperv	' p.m. LPN-C stated if essed as safe to be out on vised) they signed out at the rettes from the smoking cart					

If continuation sheet Page 49 of 82

PRINTED: 10/17/2016

		AND HUMAN SERVICES				FORM	10/17/2016 APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245187	B. WING			09/0	02/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS 1	TERRACE CARE CEN	TER			900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	and left the facility. resident was smoki supposed to get cig and no resident was or a lighter on them On 8/31/16, at 8:38 facility smoking poli "we have a sign out restricting rights if th order from the nurs felt if they are signing give them their belo leave the facility. Du has the cart and is signing out and she materials." Both acl observed R101 smo talked to her and ar residents that they to smoke." Both ind where the sidewalk not responsible if re smoking. When ask checking in smokin facility did not have R101's fall/injury as 4/1/16, indicated re- smoker. Goal "will b related to smoking [PCA]" The care pla would be kept at nu compliance to smo assist with smoking address who was re	LPN-C further stated if a ing at the patio they were garettes from the smoke cart s supposed to have cigarettes h. a p.m. when asked about the icy, the ED and DON stated t sheet, we felt we would be hey have an unsupervised se practitioner. At that point, we ng themselves out, we have to ongings back and let them uring the day, the receptionist responsible for residents e gives them their smoking knowledged they had oking outside on 8/30/16, "We re sending out a memo to all cannot assist other residents dicated the facility property was esidents were in the street ked who was responsible for g items both indicated the	F3	323			

If continuation sheet Page 50 of 82

		AND HUMAN SERVICES				FORM	10/17/2016 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245187	B. WING			09/0	02/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 900 WEST 28TH STREET		
TEXAS	TERRACE CARE CEN	TER			AINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	R101's Smoking Sa Assessment dated a dependent smoke assessment did not resident PCA was r supposed to help/si On 9/2/16, at 8:35 a supervised, depend bring her outside fo supervised R101 w facility RN-C stated follow the schedule allowed by the facilit resident was not ab they would be supe not supposed to as for them. R16's quarterly Min 7/8/16, indicated the impaired cognition, issues. On 8/30/16, at 7:28 smoking in the facil When approached, accused of smoking near oxygen. "I feel one else gets watch On 8/31/16, at 6:26 front of the building outside on the side At 6:30 a.m. the DC of the building to sp return to the building	afety Data Collection and 4/1/16, indicated resident was er with PCA assisting. The t address situations when not at the facility who was upervise with smoking. a.m. RN-C stated R101 was a dent smoker who had the PCA or smoking. When asked who hen the PCA was not at the the resident was supposed to d supervised smoking times ity. RN-C further stated if a ble light their own cigarette ervised. Another resident was sist with lighting it or holding it timum Data Set (MDS) dated e resident had severely but did not display behavioral a p.m. R16 was observed lity lower level smoking are. R16 stated he had been g in his room and smoking I 'm being watched unfairly, no	F 3	23			

If continuation sheet Page 51 of 82

		AND HUMAN SERVICES				FORM	10/17/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245187	B. WING	i		09/	02/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
TEXAS 1	TERRACE CARE CEN	TER			7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	On 8/31/16, at 6:45 R16 was to be supe stated, "I had a talk R16 had obtained t DON stated "proba 6:55 a.m. LPN-C st to smoke and had y policy. LPN-C furthe currently working w placement in a facil At 7:16 a.m. LPN-C considered a super leave of absence (I street and smoke. S not have "per sea" program. R16's Smoking Saf Assessment dated had history of smok designated areas. T indicate resident wa smoker rather it ind with the smoking po indicated resident v indicate if the reside benefit education. R16's care plan dat had congestive hea respiratory failure, a care plan assessment R16 smoked and h for the second time directed to keep sm station. The care plan was independent of even though R16 h	age 51 5 a.m. the DON again stated ervised when smoking and a with him." When asked where he smoking materials the bly from another resident." At tated R16 required supervision violated the facility smoking er stated the facility was with the LSW for R16's lity with in-door smoking room. C when a resident was vised smoker it meant on a _OA) they could go out to the She indicated the facility did a supervised smoking fety Data Collection and 8/2/16, indicated the resident king in his room and not The assessment did not as a dependent supervised dicated R16 was non-compliant olicy. Although the assessment was non-compliant it did not ent had been given risk verses ted 4/1/16, indicated resident art failure (CHF), COPD, and tracheostomy. Fall/injury ent dated 5/11/16, indicated ad been smoking in the room o n 5/11/16. The care plan noking materials at the nursing lan did not indicate if resident r dependent when smoking ad been identified as smoking supplies with him,		323			

If continuation sheet Page 52 of 82

	-	AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES	1				0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
				_			
		245187	B. WING			09/	02/2016
NAME OF F	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	TER			000 WEST 28TH STREET AINT LOUIS PARK, MN 55426		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETION DATE
					DEFICIENCY)		
F 323	Continued From pa	ao 52	F 3	00			
1 020	and had smoked in	-	гэ	23			
		g Safety policy effective July					
	2015, directed: "Supervision of the	Resident Smoking					
	 Smoking only ir 	n designated area					
		sidents who need supervision					
		cessibility of matches and lent who needs supervision"					
		effective July 2015, directed o smoke may only smoke in a					
		g area. 7. All residents who					
		assessed to be "Dependent"					
		all their smoking materials other sources of ignition,					
		cigarettes, cigars, pipes,					
		er inhaled tobacco substitutes)					
F 325		area at the nurses station". NUTRITION STATUS	F 3	25			10/12/16
SS=D	UNLESS UNAVOID			20			10,12,10
	Deced on a residen	t'a comprohensiva					
	Based on a residen assessment, the factor	cility must ensure that a					
	resident -	-					
		btable parameters of nutritional					
	unless the resident	ly weight and protein levels, s clinical condition					
	demonstrates that t	his is not possible; and					
		apeutic diet when there is a					
	nutritional problem.						
	This REQUIREMEN	NT is not met as evidenced					
	by: Based on observat	ion, interview and document			1 Resident #16 and #106 weights	hava	
	Dased on Observal				1. Resident #16 and #106 weights	nave	

Facility ID: 00144

If continuation sheet Page 53 of 82

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE	0938-039 SURVEY PLETED
		245187	B. WING		09/0	02/2016
	PROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 325	parameters of body (R16, R106) review Findings include: R16 reported on 8/3 resided at the facilit R16 explained that not let him eat and "I eat and drink whe supposed to get me aspiration pneumor R16's nutrition care R16 was nutritional disease, and was a secondary to diabe "weight will remain directed staff to pro by mouth (NPO), su weights monitored The nutrition progre- indicated R16 was tube feeding tolerar Nutrition note dated was not meeting the hydration secondar himself from the tut day to smoke. Resi the feedings to bolu tube feeding. The N and Assessment co R16 had refused a on bolus tube feedi	ailed to maintain acceptable weight for 2 of 3 residents yed for weight loss. 30/16, at 7:28 p.m. he had ty since the previous winter. the speech therapist would he was fed via a tube feeding. en I get a chance. They are e in for a swallow study. I had hia and was at the hospital." e plan dated 4/4/16, indicated ly at risk related to cardiac tt risk for dehydration tes type II. Care plan goal was stable +/-3%." Care plan ovide diet as ordered, nothing upplements were ordered and as needed (PRN) per protocol. ess note dated 4/8/16, to be followed up monthly for nce and weight stability. d 4/14/16, indicated resident e estimated nutrition and y to resident discontinuing be feeding pump during the ident had agreed to change us to help ease compliance of Autrition Risk Data Collection ompleted 7/18/16, indicated weight in July and continued ng four times daily. However, it and benefits had been	F 32	 been obtained and monitored by the dietician. A nutritional assessment been completed. The residents can is reflective of goals and intervent obtained by these tools. Residents' weights are obtained are reviewed monthly or more free accordingly to their needs. Reside nutritional risk for weight loss have reviewed and interventions are implemented and care plans are up as appropriate. Staff has been educated on we being obtained, notification of wei and potential care plan interventions specifically related to chages in w 10/12/2016. Director of Nursing/Designee w 10 resident weights per week to e completion. Director of Nursing/D will audit 3 residents nutritional assessments/care plans per weel ensure accuracy and interventions place. Audits will be completed we 1 month. Then 5 per month until discontinued by QAPI. Audit results shared at QAPI. 	t has ire plan ions d and quently ints at e been odated ights ght loss, ns eight by ill audit nsure esignee a to s in eekly for	

If continuation sheet Page 54 of 82

		AND HUMAN SERVICES				FORM	: 10/17/2016 APPROVED . 0938-0391
STATEMENT	r of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245187	B. WING _			09/	/02/2016
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS 1	TERRACE CARE CEN	TER			900 WEST 28TH STREET AINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 325	R16's nutrition Care dated 4/18/16, indic dysphagia, was to h received tube feedi R16's diagnoses into oropharyngeal phas tracheostomy, hypo diabetes type II obta Minimum Data Set addition the MDS in feedings, and "No of percent (%) or more 10% or more in last recorded in the MD During document re -R16 had no condit may result in a life of months -Was not on a plant -Had a 18 pounds (closest weight to s re-admission weight loss. -Vital SignsIndivid revealed no weights documented on adr -4/2/16, weight was -4/7/16, weight was -4/11/16, refused we -8/30/16, refused we -8/30/16, at 11:4	e Area Assessment (CAA) cated the resident had have nothing by mouth and ngs. cluded dysphagia se, gastrostomy, othyroidism, anemia and ained from the quarterly (MDS) dated 7/8/16. In ndicated R16 received tube or unknown" for loss of five e in the last month or loss of t six months with no weights 'S. eview it was revealed: ion or chronic disease that expectancy of less than 6 ned weight loss program (Ibs) weight loss program (Ibs) weight loss between the urvey and most recent at which was a 9.7% weight lual Resident Flowsheet s had been obtained or mit 11/18/16, through 4/1/16. a 199.8 lbs a 202.0 lbs hts obtained ghts obtained	F 32	25			

If continuation sheet Page 55 of 82

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/17/2016 APPROVED 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245187	B. WING	i		09/(02/2016
NAME OF PR	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS TE	RRACE CARE CEN	ΓER			/900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
ta ar ac Tiia iiosta MuO(OHV Okactrrtv tFrtsv r	about the multiple n record. The RD state assessments without document weights w The RD stated she in 4/16. The RD ind about the weight iss including the execu- of nursing on about stated "I need other board so we can ge acknowledged nutri MDS's were not accu- unavailable. On 8/30/16, at 11:44 (LPN)-C stated she obtaining the weigh however it had becco- would try again in S On 9/1/16, at 2:33 p know why R16 had asked why a swallo- completed, the RD the 'trach people' ar never be removed w transitional care uni- weight was suppose the RD stated "I wo RD acknowledged a residents was learn palancing her time to stated she had prot- weights at the time resident/chart and r	ting residents when asked nissing weights in the medical ted she was doing ut weights and had to were not obtained or refused. started working at the facility licated she had sent e-mails sues weekly to corporate, tive director (ED) and director the issue. The RD further departments to jump on et this issue resolved." The RD tional assessments and curate because weights were 4 a.m. licensed practical nurse had two months when ts had been successful, ome a problem again and they	F3	325			

If continuation sheet Page 56 of 82

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	10/17/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245187	B. WING _			09/	02/2016
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
TEXAS 1	FERRACE CARE CEN	TER			900 WEST 28TH STREET AINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 325	When asked if R16 RD stated she show weight loss betwee weights. The RD st the nurse documen provider her with up R16 was at a high would have re-eval since she had idem On 9/1/16, at 4:10 p (NP) stated she wo monitor R16's weig risk for nutritional is and refusing tube for received a call from facility indicating R out and the facility brand. The NP stat tube feeding order seen by RD but wa R16 yet. The facility Enteral 7/15, indicated the review/evaluate cha weight loss, discuss with nursing staff si recommend chang to improve/stabilize monitor the interven educate the resider each assessment a R106's quarterly M diagnoses including R106 needed set u with eating, and ha	5 had sustained a weight loss uld have been notified of the en the 4/11/16, and 8/30/16, tated she would have expected ning the weight to have pdates. The RD further stated risk for malnutrition and she uated the current interventions tified the 9.7% weight loss. p.m. the nurse practitioner puld have expected the RD to phts closely due to R16's high ssues because of the diabetes eeding. The NP stated she had n one of the nurses at the 16's tube feeding type had run needed an order for a different she had requested R16 to be as told the RD had not seen Tube Feeding policy dated dietitian was to anges in conditions such as s intolerance and/or concerns uch as weight loss, es to the physician as needed e resident nutritional status, ntions and effectiveness and to nt and family as needed during		25			

If continuation sheet Page 57 of 82

		AND HUMAN SERVICES				FORM	10/17/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245187	B. WING			09/	02/2016
NAME OF I	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	TER			900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 325	indicated R106 weig ago, and the curren The assessment di with interventions to loss. Review of the medi weights were: - 8/30/16, 148 lbs. (- No weights availal - 6/21/16, 159 lbs. (- No weights availal - 4/1/16, 167 lbs. The nurse practition 8/8/16, indicated R 26 teeth removed a bleeding secondary warfarin (a blood th hospitalized from 8/ bleeding from the to On 8/30/16, at 6:40 on his own, would s stare straight ahead R106 a straw and h R106 had pushed h plate and R106's w about using a lipped On 8/31/16, at 8:00 breakfast, had a 2 h in a bowl and a reg was provided with e indicated a divided be provided for R10 On 8/31/16, at 8:30	ghed 159 pounds 30 days at weight was not available. d not address the weight loss p reduce the risk of weight ical record indicated the (pounds) ble in 7/16 (11 lbs or a 7.4% loss) ble in 5/16 ner progress note dated 106 had dental surgery, had and had a complication of y to anticoagulant therapy on hinner). Additionally, R106 was /8/16, to 8/11/16 due to ooth extraction. 0 p.m., R106 was slowly eating stop for several minutes and d. At 7:09 p.m. staff offered he drank better out of a glass. half of the food off the regular ife asked the nurse manager d plate for R106. 0 a.m. R106 was served handle cup with a straw, cereal ular plate. No staff assistance eating. The dietary card plate with raised sides should		325			

Facility ID: 00144

If continuation sheet Page 58 of 82

		AND HUMAN SERVICES				FORM	10/17/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245187	B. WING			09/	02/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	TER			900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	Continued From pa	-	F٤	325			
	devices are on the accurate.	cart, but were not always					
	weights had been of asked for weights to assessments and n the weight for R106 address weight loss asked for a reweigh accurate. She state not a normal part of equipment would be a resident attended of 148 lbs. had not The RD stated the been addressed in R106's current care	p.m. the RD stated obtaining on ongoing issue. She had o complete nutrition not received them. Regarding 6, the assessment did not s. If it had, she would have n and assured the loss was ed that meal observations were f the assessment. Adaptive e recommended by therapy if I. The weight loss and weight been brought to her attention. oral surgeries would have the care plan by nursing.					
	R106's tooth extraction include the adaptive	s a concern and did not identify ctions. The care plan did not e equipment for eating, and dependent with eating.					
F 329 SS=D	when significant we interdisciplinary tea interventions based cause of weight los to be added to the r	d on the resident's individual is and these interventions were resident's care plan. EGIMEN IS FREE FROM	F३	329			10/12/16
	unnecessary drugs drug when used in duplicate therapy);	ig regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate					

Facility ID: 00144

If continuation sheet Page 59 of 82

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245187	B. WING			09/0	02/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS 1	ERRACE CARE CEN	TER			900 WEST 28TH STREET AINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	indications for its us adverse consequer should be reduced combinations of the Based on a compre- resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and c record; and residen drugs receive gradu behavioral intervent	se; or in the presence of nces which indicate the dose or discontinued; or any	F3	329			
	by: Based on observat review, the facility fa behaviors and effica blood pressures wh was used for 1 of 5 unnecessary medic Findings include: R37 was observed nursing station talki was appropriate an R37 returned to he From 9:00 a.m. to 1	NT is not met as evidenced tion, interview and document ailed to monitor target acy, as well as orthostatic ten psychotropic medication residents (R37) reviewed for tations. on 8/31/16, at 8:46 a.m. at the ng on the phone. The resident d calm. After the conversation, r room and shut the door. 1:00 a.m. was lying in bed. 37's mood and behavior			 Resident #37 has been given co for Seroquel, her behaviors have be reviewed, and residents NP has be updated, her orhtostatic blood press has been obtained. Residents with psychotropic medications have had their behavior reviewed and documented on their behavior care plan upon admission quarterly, and with signficant chang Residents with current psychotropic medication usage have been review and have been give consent and has their orthostatic blood pressure take monthly basis. Unit Managers, License Nurses a 	een en sure ors , es. c ved ave en on a	

Facility ID: 00144

If continuation sheet Page 60 of 82

PRINTED: 10/17/2016

STATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245187	B. WING _		09/	02/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
TEXAS 1	ERRACE CARE CEN	TER		7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIC DATE
F 329	the resident had a psychotropic drug of R37 used Trazodor Seroquel for traum decline. The care p hypotension (sudder rising, common wit use), behavior and deterioration. A psychotropic drug (CAA) for R37 dater resident used Sero addition, the CAA in adverse effects fro- review the care plat R37's physician or orders for the antip (for Seroquel) 25 m behavioral disturbat commonly used to mg at bedtime for of R37's diagnoses in brain injury and sei the quarterly MDS MDS indicated R37 had severely impai On 8/31/16, at 12:2 the behavior of cur at others. At times re-approached an I pleasant. LPN-A fu support system and	nent dated 11/10/15, indicated potential for side effects from use. The care plan identified ne for depression and atic brain injury with cognitive olan directed staff to monitor for en drop in blood pressure with h psychotropic medication d cognitive impairment g use Care Area Assessment ed 11/19/15, indicated the quel and Trazodone. In ndicated R37 had potential for m medications and directed to n for interventions. ders dated 6/6/16, revealed sychotic, quetiapine fumarate ng twice daily for dementia with unces and the antidepressant promote sleep,Trazodone 150 depression.	F 32	Social Services Department educated on documenting by the behavior care plan, on presidents with consent sheet utilizing medications, and morthostatic blood pressure by 4. Director of Social Services audit 5 residents per week for target behaviors and behav are documented and consist of psychotropic medications Nursing/designee to audit 5 week to ensure orthostatic for are completed monthly and given to residetns appropriat will be completed weekly for Then 5 per month until disc QAPI. Audit results will be st QAPI.	behaviors on providing ets when ionitoring of by 10/12/2016. es/designee to to ensure ior care plans tent with goals bior care plans tent with goals tent with	

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	10/17/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245187	B. WING	ì		09/(02/2016
NAME OF !	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
TEXAS 1	TERRACE CARE CEN	TER			7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	On 9/1/16, at 6:45 a never had any phys kicking or harming aware of. LPN-B inverbally aggressive they had establishe On 9/1/16, at 9:31 a did not have a Serce use and R37 had n In addition, LPN-C pressures were obt further stating "The least once a month use." On 9/1/16, at 10:06 (LSW)-A acknowled not been completed LSW-A stated the s on only one occasio one had been track ensure behavior mod LSW-A further stated department had jus would help closely a documentation of b On 9/1/16, at 4:09 p (NP) stated she wo complete behavior had occasional psy with R37 that media comfort and well be would have expected orthostatic blood pr antipsychotic media	a.m. LPN-B stated R37 had sical behaviors of hitting, self or other that she was dicated the resident was very e toward staff, depending if ed a rapport with her. a.m. LPN-C stated R37's chart opuel consent for medication to behavior monitoring in place. stated no orthostatic blood tained in the last three months ey are supposed to be done at a for psychotropic medication 6 a.m. licensed social worker dged behavior monitoring had d for R37 for the last 90 days. staff had documented behavior on. LSW-A acknowledged no king the documentation to onitoring was being completed. ed the social services st filled the positions which	F	329			

If continuation sheet Page 62 of 82

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	. 0938-039
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CON	IPLETED
		245187	B. WING		09/	/02/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS 1	ERRACE CARE CEN	TER		7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 329	Continued From pa	ge 62	F 32	9		
F 334 SS=D	stated she also wou behaviors to be mo pressures to be che	o.m. the director of nursing uld have expected the nitored and orthostatic blood ecked monthly. NZA AND PNEUMOCOCCAL	F 33	4		10/12/16
	that ensure that (i) Before offering the each resident, or the representative recerbenefits and potent immunization; (ii) Each resident is immunization October annually, unless the contraindicated or the immunized during the transmunization; and the resident or representative has immunization; and the resident or representative has immunization; and the benefits and poly the benefits and poly immunization; and the benefits and poly immuniz	ives education regarding the ial side effects of the offered an influenza ber 1 through March 31 e immunization is medically he resident has already been his time period; the resident's legal the opportunity to refuse medical record includes indicates, at a minimum, the ent or resident's legal provided education regarding tential side effects of influenza ent either received the tion or did not receive the tion due to medical r refusal.				

If continuation sheet Page 63 of 82

		AND HUMAN SERVICES				FORM	10/17/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245187	B. WING			09/	02/2016
	PROVIDER OR SUPPLIER	TER	STREET ADDRESS, CITY, STATE, ZIP CODE 7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334	immunization, each legal representative the benefits and po- immunization; (ii) Each resident is immunization, unlea- medically contrained already been immun (iii) The resident or representative has immunization; and (iv) The resident's re- documentation that following: (A) That the resider representative was the benefits and po- pneumococcal immediate pneumococcal immediate pneumococcoccal immediate pneumococ	a resident, or the resident's e receives education regarding otential side effects of the a offered a pneumococcal ss the immunization is licated or the resident has unized; the resident's legal the opportunity to refuse medical record includes t indicated, at a minimum, the ent or resident's legal provided education regarding otential side effects of nunization; and ent either received the nunization or did not receive immunization due to medical refusal. e, based on an assessment commendation, a second nunization may be given after 5 first pneumococcal ss medically contraindicated or resident's legal representative	F3	334			
	by: Based on interview facility failed to imp related to the pneu	NT is not met as evidenced v and document review, the lement a policy and procedure mococcal conjugate vaccine to recommendations by the			 Resident #64 has been ordered offered PVC13. Currently, waiting f spousal consent. Resident's upon admission and 		

Facility ID: 00144

		AND HUMAN SERVICES			FORM A	10/17/2016 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED			
		245187	B. WING		09/02/2016			
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
TEXAS T	ERRACE CARE CEN	TER	7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 334		-	F 334					
		e Control (CDC) for 1 of 5 ose vaccination histories were		annually will be reviewed for immunization needs. Resident's pneumococcal audit has been comp and residents whom have not receiv				
	Findings include:			PCV13 have been offered the immunization.	_			
	indicated the 79 yea Pneumovax in 2007	n Record dated 7/28/09, ar old resident received the 7. There was no evidence he ne PCV13 vaccine since his cility in 2007.		 3. Licensed nurses have been edu on the administration of PCV13 by 10/12/2016. 4. Director of Nursing/designee w 3 residents per week for one mont ensure they have been informed/o 				
	The CDC recommendations indicated, "Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 [pneumococcal polysaccharide vaccine 23] should receive a dose of PCV13. The dose of PCV13 should be administered at least one year after the most recent PPSV23 dose."			pneumococcal appropriately. Then 3 month unitl discontinued by QAPI. A results will be shared at QAPI.	3 per			
	(DON) stated the ne pneumococcal vaco	a.m. the director of nursing ew guidelines for updating cines had been partially facility. The DON stated R64 n updated vaccine.						
	adults 65 years of a PCV13 followed by polysaccharide vace later."	vaccination policy indicated "All age or older receive a dose of a dose of pneumococcal ccine (PPSV23) at least 1 year						
F 356 SS=C	483.30(e) POSTED) NURSE STAFFING	F 350	6		10/12/16		
	The facility must po a daily basis: o Facility name.	ost the following information on						

Facility ID: 00144

If continuation sheet Page 65 of 82

		AND HUMAN SERVICES & MEDICAID SERVICES		FORM /	APPROVED 0938-0391				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		245187	B. WING _		09/0	02/2016			
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
TEXAS 1	TEXAS TERRACE CARE CENTER			7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426					
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 356	by the following cat unlicensed nursing resident care per sh - Registered nu - Licensed prac vocational nurses (a - Certified nurses o Resident census. The facility must po specified above on of each shift. Data o Clear and readab o In a prominent pla residents and visito The facility must, up make nurse staffing for review at a cost standard. The facility must ma staffing data for a n required by State la This REQUIREMEN by: Based on interview facility failed to ensi- correct for the num providing care in the potential to affect a Findings include:	and the actual hours worked egories of licensed and staff directly responsible for nift: rses. tical nurses or licensed as defined under State law). e aides. est the nurse staffing data a daily basis at the beginning must be posted as follows: le format. ace readily accessible to	F 3	56 1. Staffing hours will be posted in prominently visible resident area or daily basis including facility name, or date, and the total # of hours and a hours worked by licensed and unlic nursing staff directly responsible for resident care. Facility Executive Dir will ensure accuracy in daily posting 2. Staffing coordinator, NHA, DON,	current ictual censed r rector gs.				

Facility ID: 00144

If continuation sheet Page 66 of 82

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		E SURVEY		
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COM	PLETED		
		245187	B. WING _		09/02/2016			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE			
EXAS 1	ERRACE CARE CEN	TER		7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE		
F 356	reflected the number licensed practical n medication assistant the full time equivel incorrectly. For exa nursing assistants (when the actual how versus 96 hours, as shifts. Additional staff pos The 6/1/16, staff pos The 6/1/16, staff pos The 6/1/16, staff pos the number of RNs and had not been u addition, the FTE w example on the ever as 11 FTE, when th 75 hours, not 88 ho shifts, not 11 FTE of employees working However, the facilit and 7.5 shifts, but t full. The 6/2/16, staff pos number of RN, LPN not been updated w FTE was calculated the evening shift the when the actual how FTE, 10 people wor (four of the 10 peop and 6 worked 7.5 h The 6/8/16, staff pos number of RN, LPN	er of registered nurses (RN), urses (LPN), and trained nts (TMA) working. In addition, lent (FTE) was calculated mple, on the evening shift the (NA) were listed as 12 FTE, urs worked totaled 81 hours is the NAs had worked partial tings reviewed included: osting inaccurately reflected , LPNs, and TMAs working updated with changes. In vas calculated incorrectly. For ening shift the NA's were listed the actual hours worked totaled burs. 11 NA's worked partial of NA's. [1 FTE= 80 hours, 10 8 hour days would = 1 FTE]. y used partial shifts 6.0, 7.3, hen counted partial shifts as osting was not accurate for the N, and TMA working and had with changes. In addition the d incorrectly, for example, on e NA's were listed as 10 FTE, urs worked totaled 69, or .86 rked partial shifts, not 10 FTE ble worked only 6 hour shifts	F 35	56 Business Office Manager h educated about calculating daily staffing sheet by 10/12 3. Business Office Manage audit daily staffing sheets of to ensure accuracy of FTE of census. Results of daily shared in QAPI. Daily audit for one month. QAPI comm determine legnth of time au	FTE's for the 2/2016. r/Designee will n weekly basis calculation and audit will be s performed nittee will			

If continuation sheet Page 67 of 82

		RINTED: 10/17/2016 FORM APPROVED MB NO. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
245187 B. WING		09/02/2016
NAME OF PROVIDER OR SUPPLIER STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
I TEXAS TERBACE CARE CENTER	WEST 28TH STREET NT LOUIS PARK, MN 55426	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIXTAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 356 Continued From page 67 F 356 as 11 FTE, when the actual hours worked totaled 88.50, or 1.11 FTE, 11 people worked partial shifts, not 11 FTE (six of the 11 people worked only 6 hour shifts and 7 worked 7.5 hour shifts). The staff posting for 6/9/16, was not accurate for the number of RN, LPN, and TMA working. In addition the FTE was calculated incorrectly, for example on the night shift the NA's were listed as 5 FTE, when the actual hours worked totaled 52.30, or .65 FTE, 7 people worked partial shifts, not 5 FTE's. On Day shift 12 people worked a total of 90 hours, which equaled 1.13 FTE not 11.0 FTE. On 6/10/16, the staff posting was not accurate for the number of RN, LPN, and TMA working. In addition the FTE was calculated incorrectly, for example, on the evening shift the NA's were listed as 12 FTE, when the actual hours worked totaled 66.50, or .83 FTE, 12 people worked partial shifts, not 12 FTE's. On 9/1/16, at 2:30 p.m. an interview was conducted with the staffing coordinator and director of nursing. At 3:50 p.m. the administrator joined the interview and stated he was unaware that nurse managers and assistant nurse managers could not be counted in staffing unless they were providing direct patient care. A clarification was provided, if a portion of their day was in direct patient care, then that portion could be reflected on the staff posting, but not time spent in administrative duties. An undated letter sent to the staffing coordinator by the administrator directed, "All nurses, including nurse managers, must be included on the staffing form." Staff postings from June of 2016 going forward noted that some of the days the nurse		

If continuation sheet Page 68 of 82

TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED
			A. BUILDIN	IG		
		245187	B. WING _		09/02/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7900 WEST 28TH STREET		
TEXAS T	ERRACE CARE CEN	TER		SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 356	Continued From pa	aae 68	F 35	6		
	managers and the	assistant nurse managers time in the posting even though the				
F 441 SS=D	· · ·	N CONTROL, PREVENT	F 44	1		10/12/16
	Infection Control Pr safe, sanitary and c	stablish and maintain an rogram designed to provide a comfortable environment and development and transmission ction.				
	Program under whi (1) Investigates, co in the facility; (2) Decides what p should be applied t	stablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective				
	determines that a r prevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus hands after each di	tion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ease or infected skin lesions with residents or their food, if ransmit the disease. t require staff to wash their irect resident contact for which dicated by accepted				
	(c) Linens Personnel must ha	ndle, store, process and				

If continuation sheet Page 69 of 82

		AND HUMAN SERVICES			FORM	10/17/2016 APPROVED 0938-0391		
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED		
		245187	B. WING		09/02/2016			
NAME OF I	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE				
			7900 WEST 28TH STREET					
TEXAST	FERRACE CARE CEN	IER	S	AINT LOUIS PARK, MN 55426				
(X4) ID PREFIX TAG	RÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE				
F 441		age 69 as to prevent the spread of	F 441					
	by: Based on observative for the facility for infection control metacares for 1 of 1 resifieeding and 3 of 3 or reviewed for wound. Findings include: R120 had a gastross 9:00 a.m. registered R120's medications her hands in R120's RN-D touched the gG-tube site which we RN-D continued to administered the metacon subserver flushes to R120 after 0 n the second wated disconnected and so come out of the G-1 re-connected the ture RN-D removed her and medications are without washing her removed the gloves holding the pair of gRN-D did not washer by the surveyor at t she had not washer the factor of the second wated for the second the second the second the second the second the factor of the G-1 removed the gloves holding the pair of gRN-D did not washer the second the	stomy tube. On 8/31/16, at d nurse (RN)-D was set up s. At 9:17 a.m. RN-D washed s room and applied gloves. gauze dressing around R120's vas soiled with dried blood. check tube placement then redications mixed together. d give 30 milliliter (mI) water er two rounds of medications. er flush the syringe and G-tube stomach fluid was observed to		 Residents #39, #75, #172, and a have had cares provided for them p appropriate infection control guideli hand hygiene. Residnet #172 has discharged home successfully. Identified staff have completed or one education regarding appropriate infection control procedures for ead witnessed incident. Residents with drug resistant organisms infection wounds have been placed on approprecautions. Licensed nurses will be educated infection control practice for g-tube wound care duties by 10/12/2016. DON/Designee will audit 1 g-tube wound dressings per week for one to ensure/teach appropriate infectio control measures with the staff. The g-tube, 2 wound dressings per mor discontinued with QAPI. Results of will be shared at QAPI. 	orer ines for one on te ch multi of opriate d on and e and 2 month on en 1 nth until			

Facility ID: 00144

If continuation sheet Page 70 of 82

		AND HUMAN SERVICES				FORM	10/17/2016 APPROVED		
STATEMENT	TOF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION	(X3) DAT	0938-0391 E SURVEY PLETED		
		245187	B. WING	i		09/	02/2016		
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
TEXAS 1	ERRACE CARE CEN	TER	7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 441	flushes. On 9/1/16, at 9:38 a (LPN)-C stated she to change gloves by between gloves cha room. On 9/1/16, at 4:23 p stated staff was sup removing gloves an pair between cares R172's Physician's hospital dated 8/25, to dry dressing cha diagnosis of infecte muscle. The hospita an infected coccyge precautions implem treatment with Van milligrams intravend R172's Minimum D indicated R172 was memory issues and on the coccyx. R172 was observed R172 had a open d R172 stated she was for the nurse to dre a dry washcloth on washcloth and a lar coccyx was observed On 9/1/16, at 11:40	stering the medications and a.m. licensed practical nurse e would have expected the staff etween cares, wash hands anges and before leaving the o.m. director of nursing (DON) posed to wash hands after nd before re-applying another Orders on discharge from the /16, included an order for wet nge twice a day, and a ed ulcer of skin with necrosis of al discharge notes indicated eal ulcer with contact nented on 8/24/16, and comycin (antibiotic) 1,000 ously at dialysis. ata Set (MDS) dated 7/28/16, s cognitively intact, had no d had an unstageable wound d on 8/30/16, at 11:00 a.m. leep wound to the coccyx. ashed it out and was waiting ss the wound. The wound had it. R172 removed the rge tunneling wound on the	F	441					

If continuation sheet Page 71 of 82

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/17/2016 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245187	B. WING			09/	02/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS	TERRACE CARE CEN	TER			900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	after an incontinent wound had been so washcloth in place she was not familia out. R172 stated RI solution to clean the redirected her to ge RN-A washed her h cleansed the wound gauze. RN-A packet covered it with Alley The nurse threw the on the floor and sai later. After complet removed her gloves picked up the soiled from the floor. With soiled gloves and w placed them in the wash her hands, th supplies, pushed ba room. On 9/2/16, at 8:10 a (DON) stated R172 hospitalized for a w had been cultured fi Staphylococcus Au resistant bacteria). R172 removed the and used a washcle DON acknowledged have been implement and was not covere The DON also state all soiled gloves, dr	washed the wound herself episode. R172 stated the biled. R172 had a dry on the wound. RN-A stated r with R172, but was helping N-A did not have the correct e wound, and the resident et the "blue bottle." ands and applied gloves then d with wound cleaner on d wound with wet gauze and rvn (an occlusive dressing). e soiled gloves and wrappers d she would pick up them up ing the dressing change RN-A s, washed her hands, then d gloves and paper wrappers out gloves RN-A picked up the rrapper from the floor and garbage can. RN-A did not en gathered the wound ack the curtain, and left the	F 4	141			

If continuation sheet Page 72 of 82

	AND HUMAN SERVICES				FORM	APPROVED			
	TOF DEFICIENCIES					MB NO. 0938-0391 (X3) DATE SURVEY			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /				IPLETED		
			/		*				
		245187	B. WING	B. WING			02/2016		
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE				
TEXAS T	ERRACE CARE CEN	TER		7900 WEST 28TH STREET					
			L		SAINT LOUIS PARK, MN 55426				
(X4) ID PREFIX		TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE		
	1								
F 441	Continued From pa	000 72	F4	11					
1 771	floor.	.ge 72	Гч	<u>4</u> 1	1				
	R75 was admitted t	to the facility with a							
	non-pressure chror	nic heel ulcer. R75's admission							
		(MDS) assessment dated							
		R75 was admitted with two ulcers. The assessment							
		s were covered in eschar							
		n tissue that adheres firmly to							
	the wound bed or u	lcer edges, may be softer or							
	harder than surrour	nding skin).							
	R75's careplan date	ed 8/9/16, indicated an							
		eel ulcer with black eschar.							
	The careplan direct	ted staff to monitor the wound							
		els and offload the resident							
		ohysician orders signed aff to "clean right heel every							
		ney, then cover with adaptic							
	and gauze."								
		the DRE shares all's							
		1 a.m. R75 was observed in his wheelchair. R75's right foot							
		ht shoe and sock was sitting							
		e next to R75. R75's foot was							
		ight wheelchair foot rest and							
		e was observed on the floor							
		t. A soiled gauze was on the							
		inage. R75 stated that the to see him and he was waiting							
		ne and wrap the wound. At							
		as interviewed and was							
		d was not wrapped. RN-A							
	immediately sent R	N-B to dress R75's wound.							
	On 9/1/16. at 1:24 r	o.m. RN-A completed R75's							
		RN-A washed her hands,							
	donned gloves and	cleaned the scissor before							
		sing change. R75 was in his							
	wheelchair during t	he dressing change. RN-A sat							

If continuation sheet Page 73 of 82

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· · /	(X3) DATE SURVEY COMPLETED 09/02/2016	
		245187	B. WING		09		
NAME OF	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CO	DE		
TEXAS 1	ERRACE CARE CEN	ITER		7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
F 441	over her knee. She sock and placed hi her knee. RN-A cur removed the dressing scissor on the floor observed on the ol towel on the floor a towel. RN-A took th and placed them o scissor. RN-A then removed her glove antibacterial foam, sat back down in th washcloths on her washcloths to cont RN-A sprayed salin the wound with gau garbage. RN-A ren gloves and applied bed and covered w to complete the dre the washcloths from on the floor. The w green drainage fro removed her glove RN-A kicked the w to look for the sciss the washcloths, sh the floor. RN-A the linen bag to dispose the room with soile interviewed and co obtain the linen bag	age 73 om and set several washcloths e then removed R75's shoe and is foot on the washcloths over t the old dressing gauze and sing from R75's foot. RN-A g in the garbage and set the r. Green drainage was d dressing. RN-A set another and placed R75's foot on the ne washcloths from her knee n the floor on top of the g ot up from the chair, es, sanitized her hands with and donned new gloves. RN-A ne chair, applied clean knee and put R75's foot on the inue with the dressing change. Ne wash on the wound, wiped uze and threw the gauze in the noved her gloves, donned new I Medi-Honey on the wound <i>v</i> ith Vaseline gauze and Kerlix essing change. RN-A removed m her knee and placed them rashcloths were soiled with m the wound. RN-A then es. Before leaving the room, ashcloths around on the floor sor. After finding scissor under e picked up the scissor from n stated she was going to get a se of the soiled linen, leaving ed linen on the floor. RN-A was build not state why she did not g, prior to beginning the n order to avoid placing soiled	F 4	41			

If continuation sheet Page 74 of 82

		AND HUMAN SERVICES				FORM	10/17/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245187	B. WING			09/	02/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
TEXAS T	ERRACE CARE CEN	TER			900 WEST 28TH STREET AINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	on 8/29/16 at 12:45 was open to air with wound. Clear, pink running down R39's interviewed and sta been dressed today observed sitting in I station. R39's right with no dressing in observed from the v 3:36 p.m. R39 was wheelchair with her drainage from the v outside of the woun explained the "dres today" but those wh dressing change ha On 8/29/16, at 3:53 treatment sheets w signed off R39's wo p.m. RN-A was inte wound doctor saw I wounds should hav she "typically does each floor, but need floor." RN-A stated dressing change wi said the wound doc supplies that day. V wound draining on there was typically a drainage, but did no that day. On 9/2/16, at 8:10 a (DON) confirmed n soiled gloves, dress	inge 74 is p.m. R39's right leg wound hout a dressing covering the drainage was observed is leg from the wound. R39 was ited that the wound had not y. At 2:20 p.m. R39 was her wheelchair by the nurses' leg wound was open to air, place. Dried drainage was wound to the residents foot. At observed outside in her right leg uncovered. Dried wound was observed from the ad down to R39's foot. R39 sing should have been done to usually complete the ad gone home for the day. F.p.m. R39's medication ere reviewed. LPN-C had bund care for the day. At 3:54 rrviewed. RN-A stated the R39 and R75 that day and the re been covered. RN-A stated go with the wound doctor to ded to help up on second she usually completed the hen on wound rounds. RN-A ctor told her that he had the Vhen asked about R75's to the floor, RN-A replied that a towel down on the floor for ot know why there was not one	F 4	41			

If continuation sheet Page 75 of 82

		AND HUMAN SERVICES				FORM	10/17/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			(X3) DATE	E SURVEY PLETED
		245187	B. WING	i		09/	02/2016
NAME OF F	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	TER			7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441 F 496 SS=E	The DON explained with the the physicia the responsibility fo The facility's 7/15, N Organisms (MDRO hand hygiene upon resident's room, uti all residents with M precautions when in indicated residents standard precaution secretions/excretion Secretions/secretion Secretions/secretion when they do not lee products." 483.75(e)(5)-(7) NL VERIFICATION, RE Before allowing an aide, a facility must that the individual h requirements unles employee in a trainine valuation program individual can prove successfully comple competency evalua evaluation program has not yet been in Facilities must follo individual actually b Before allowing an aide, a facility must State registry estab (2)(A) or 1919(e)(2)	d that a nurse typically went an on wound rounds and had r dressing the wounds. Multi-drugResistant) policy directed staff to "use entering and leaving a lize standard precautions for DRO and implement contact ndicated." The policy further "shall be cared for under ns for managing ns (including wound drainage). ns are defined as contained eak out of containment URSE AIDE REGISTRY ETRAINING individual to serve as a nurse receive registry verification as met competency evaluation s the individual is a full-time ing and competency approved by the State; or the e that he or she has recently		441			10/12/16

If continuation sheet Page 76 of 82

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			PF		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0		0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245187	B. WING			09/0	02/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	TER			900 WEST 28TH STREET		
//				S	AINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 496	Continued From pa	ge 76	F4	96			
	If, since an individua a training and comp there has been a co- consecutive months individual provided services for moneta individual must com- competency evalua competency evalua This REQUIREMEN by: Based on interview facility failed to ensu- (NAs) had complete a valid testing agen potential to affect 70 2nd floor. Findings include: On 12/1/15, a public Department of Heat for 569 NAs for per- tested to become fe- included the Inver H Center for Professio Development and it Online in West St. F and October 16, 20 investigators found results associated w questions about relia	al's most recent completion of betency evaluation program, ontinuous period of 24 is during none of which the nursing or nursing-related ary compensation, the hplete a new training and tion program or a new tion program or a new tion program. NT is not met as evidenced and document review, the ure all nursing assistants ed a competency testing from cy as required. This had the 0 residents on 1st floor and c notice by the Minnesota th (MDH), requiring re-testing sons who were previously ederally qualified NAs. This fills Community College onal and Workforce is satellite location at Blue Sky Paul between May 1, 2014, 15. The move came after evidence of anomalies in test with the two sites, raising fability.			 The staff member has been suspended indefinitely until they act valid nursing assistance license. Nursing assistances have been a to ensure they have a valid nursing assistance license. Human Resources director will b provided with education regarding a nursing assistances need a valid lice they are to work at Texas Terrace C Center by 10/12/2016. Business Office Manager/Design complete 5 audits per week of hum resources files to ensure valid licen are obtained for all current nursing assistants. Then 5 audits per month contine until discontinued by QAPI. Results of audits will be shared at C 	e all ense if care nee will an ses n will	
	took the tests at the	two locations during the time to October 2015 may have					

If continuation sheet Page 77 of 82

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	10/17/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		X3) DATE	E SURVEY PLETED
		245187	B. WING				09/0	02/2016
NAME OF F	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZI	P CODE		
TEXAS T	ERRACE CARE CEN	TER			900 WEST 28TH STREET	26		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD E HE APPROPRI		(X5) COMPLETION DATE
F 496	MDH took precaution individuals tested at that timeframe, with NAs affected could were required to re- 2016. Any individual re-testing by that dat ineligible to work as nursing home or both addition, many state not to hire individual re-test. NA-A had a NA com- centers listed above 12/15, stating re-test by 3/31/16. NA-A we nursing home until NA's status was chan Registry effective 4. The facility failed to completed re-testin on the NA Registry. facility after inactive 8/19/16. NA-A work and was scheduled facility staff reported from the schedule f During an interview human resources d	he potential improprieties, ons requiring re-testing for all t those two locations during nout cost to the individuals. continue to work, however, test no later than March 31, ils who did not pass the ate would be considered a NA at a federally certified ard and care home. In e licensed employers chose ils who had not passed the hpetency from one of the e. A letter was sent to NA-A in sting needed to be completed as not eligible to work in the the tests were passed, and the anged on Minnesota's NA /1/16. verify all NAs affected had g as required, and were active NA-A continued to work in the e status from 4/1/16 through ed in the facility on 9/1/16, to work again on 9/2/16. The d NA-A would be removed	F 4	196				
F 518	NA-A's status on th	hould have also verified e Registry. N ALL STAFF-EMERGENCY	F٤	518				10/12/16

If continuation sheet Page 78 of 82

		AND HUMAN SERVICES				FORM	10/17/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245187	B. WING			09/0	02/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	TER			900 WEST 28TH STREET AINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 518 SS=C	PROCEDURES/DF The facility must tra procedures when th periodically review is staff; and carry out those procedures. This REQUIREMEN by: Based on document facility failed to train emergency procedu Findings include: Employee personal for training in disas preparedness. E2 v personal file lacked facility's emergency 5/3/16, and E3's pet training in the facilit The human resource 9/9/16, at 9:00 a.m. documentation in E	AILLS ain all employees in emergency hey begin to work in the facility; the procedures with existing unannounced staff drills using NT is not met as evidenced nt review and interview, the n 2 of 5 employees (E2, E3) on ures.	F 5	518	 The staff memebers identified hare recieved the disaster and emergency training. Staff inservice records have been audited to ensure they have recieved disaster and emergency training. Human resource director and field education director (reponsible for georeitation) have been provided educt that all staff need to be given disaster emergency training before completing general oreintation by 10/12/2016. Business Office Manager/Design complete 5 audits per week of huma resources files to ensure emergency education has been provided to all r hires. Then 5 audits per month will continue until discontinued by QAPI 	cy d ed eneral cation er and on of ee will an y new	
F 520 SS=F	indicated the facility effort to safeguard physical environme a fire."	ed FireLong Grass policy, y would "make every possible the residents, staff, and ont of the facility in the event of IBERS/MEET	F 5	520	Results of audits will be shared at C	QAPI.	10/12/16

Facility ID: 00144

If continuation sheet Page 79 of 82

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM /	10/17/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245187	B. WING			09/0	02/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	TER			900 WEST 28TH STREET AINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 520	Continued From pa	-	F 5	520			
	assurance committ nursing services; a	tain a quality assessment and ee consisting of the director of physician designated by the 3 other members of the					
	committee meets a issues with respect and assurance acti- develops and imple	ment and assurance t least quarterly to identify to which quality assessment vities are necessary; and ments appropriate plans of entified quality deficiencies.					
	disclosure of the re except insofar as s	retary may not require cords of such committee uch disclosure is related to the committee with the s section.					
		by the committee to identify deficiencies will not be used as s.					
	by: Based on interview facility failed to ens (QA) committee red action plan to addre supervision related residents (R16, R99 identified as needin In addition the facili practices in the are	NT is not met as evidenced y and document review, the ure the Quality Assurance cognized and developed an ess an identified lack of to smoking for 5 of 7 5, R101, R118, R177) g supervision while smoking. ty failed to improve upon as of abuse reporting, cations and infection control			 QA meets on a monthly basis and identified quality issues and action p are developed and reviewed. The quality assurance committee met on 9/23/2016. The QA committee medical director reviewed the smoki policy/ procedure and have made changes as appropriate. The quality assurance committee also discussed immediate safety plan for resident 	lans last ee and ing	

Facility ID: 00144

If continuation sheet Page 80 of 82

	CONTRACT	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	LE CONSTRUCTION		0938-039 SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245187	B. WING _			09/0	02/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS 1	ERRACE CARE CEN	TER			900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 520	survey on 9/17/15. potential to affect a Findings include: Refer to F323: the adequate supervisi R95, R101, R118, F unable to safely lea smoke. During an interview executive director (a physician's order facility unsupervise the sidewalk in from stated the residents smoking materials there was currently smoking materials there was currently smoking materials there was currently smoking area outsi further stated he was did not have an ord been observed smo unsupervised durin Refer to F225 and immediately report designated State an accordance with fa (R19, R29, R40, R7 by facility staff.	in a previous recertification These practices had the II 101 residents in the facility. facility failed to provide on for 5 of 7 residents (R16, R177) who were identified as ave the facility unsupervised to on 8/31/16, at 8:38 a.m. the ED) stated residents who had allowing them to leave the d were allowed to stand out on at of the facility to smoke. He is were to sign out their before going outside, however, in o plan in place to check the when the residents returned to D stated for residents not o smoke unsupervised could ed times in the supervised de the lower level. The ED as aware some residents who ler to leave the facility had oking on the sidewalk g the survey. F226: the facility failed to allegations of abuse to the gency (SA) as required and in cility policy for 4 of 5 residents 75) who alleged mistreatment	F 52	20	abuse/neglect and its current implmentation. The next QA meetin scheduled for 10/12/2016 where re unnecessary medication concerns infection control concerns will be discussed along with all other defic from the current survey and the pla correction to fix above deficiencies the current survey and the plan of correction to fix above deficiencies 3. DCS/designee will audit monthly minutes to ensure implementation follow through has been document executed for action plans and performance improvement plans. Executive Director/ designee will fo QAPI audits to the monthly QAPI committe monthly for 3 months for continued opportunities for improve	view of and iencies in of from QA and ed and	
	by facility staff. Refer to F329: The	facility failed to implement ring for the use of psychotropic					

If continuation sheet Page 81 of 82

		AND HUMAN SERVICES			FORM	: 10/17/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245187	B. WING _		09/	02/2016
NAME OF I	PROVIDER OR SUPPLIER		· [STREET ADDRESS, CITY, STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	TER		7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 520	Continued From pa medications.	ge 81	F 52	20		
	appropriate infectio	facility failed to implement n control measures to reduce during wound care.				
	A facility policy rega requested but none	arding quality assurance was was received.				

Facility ID: 00144

		AND HUMAN SERVICES		F6187025	FORM): 10/17/2016 APPROVED
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01	(X3) DA1	0. 0938-0391 TE SURVEY MPLETED
		245187	B, WING		09	/01/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
TEXAS T	ERRACE CARE CEN	TER		7900 WEST 28TH STREET SAINT LOUIS PARK, MN 554	26	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs	ĸ	000		
	FIRE SAFETY					
	ALLEGATION OF O DEPARTMENTS A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.				
	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 HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.					
	Minnesota Departm Fire Marshal Division the time of this surv Center was found r	Survey was conducted by the nent of Public Safety, State on on September 01, 2016. At yey, Texas Terrace Care not in substantial compliance hts for participation in				
	Medicare/Medicaid Life Safety from Fir National Fire Prote	, 42 CFR, Subpart 483.70(a), e, and the 2000 edition of ction Association (NFPA) Safety Code (LSC), Chapter				
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY				-
	Healthcare Fire Ins State Fire Marshal 445 Minnesota St., St. Paul, MN 55107	Division Suite 145		EF	POC	
	By email to:					
	y director's or provit hically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 10/16/2016

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.

Facility ID: 00144

		& MEDICAID SERVICES				0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (01 - MAIN BUILDING 01		SURVEY PLETED		
		245187	B, WING		09/01/2016			
NAME OF 1	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
TEXAS T	ERRACE CARE CEN	ITER		7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE		
K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us		K 000					
		RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:						
	 A description of what has been, or will be, done to correct the deficiency. The actual or proposed completion data 							
	2. The actual, or pr	roposed, completion date.						
	responsible for cor	or title of the person rection and monitoring to ence of the deficiency.						
	no basement. The constructed in 197 TYPE I(332) Const was constructed to determined to be o	e Center is 3-story building with original building was 2 and was determined to be of truction. In 1995 an addition o the west and it was of TYPE I(332) Construction. It orinkler protected throughout.		5				
	detection in the con corridors that is mo department notifica	re alarm system with smoke rridors and spaces open to the politored for automatic fire ation. The facility has a ds. At the time of the survey						
K 029 SS=E	NOT MET as evide NFPA 101 LIFE SA	FETY CODE STANDARD	K 029	9		10/16/16		
	fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro	d construction (with o hour r an approved automatic fire em in accordance with 8.4.1 otects hazardous areas. When matic fire extinguishing system						

Facility ID: 00144

If continuation sheet Page 2 of 6

TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION (X3) DA). 0938-0391 TE SURVEY MPLETED
		245187	B. WING		/01/2016
NAME OF I	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	/01/2010
TEXAS T	ERRACE CARE CEN	ITER		900 WEST 28TH STREET AINT LOUIS PARK, MN 55426	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
К 029	other spaces by sr doors. Doors are field-applied protect 48 inches from the permitted. 19.3. This STANDARD Based on a facility facility failed to pro- areas in accordance NFPA 101 -2000 e 8.4.1. This deficient residents within the Findings include: On a facility tour b 01:00: PM on Sep revealed that the S	areas are separated from noke resisting partitions and self-closing and non-rated or ctive plates that do not exceed a bottom of the door are 2.1 is not met as evidenced by: y tour and staff interview, the ovide protection of hazardous ce with the requirements of dition, Section 19.3.2.1 and nt practice could affect all e smoke compartment. etween the hours of 09:00 AM tember 01, 2016, observation Staffing Central Supply room nt of combustible storage, but	К 029	 A self closing door will be installed to the Staffing Central Supply room. The self closing door was installed on October 14th, 2016. The Director of Maintenance will be responsible for ensuring the installation occurs and the unit operates appropriate moving forward. 	ŀy
K 054 SS=F	Administrator at the NFPA 101 LIFE S/ All required smoke activating door hol maintained, inspec- with the manufactur This STANDARD Based on docume the facility has not testing of the smo system in accorda	tice was verified by the the time of inspection. AFETY CODE STANDARD e detectors, including those ld-open devices, are approved, cted and tested in accordance urer's specifications. 9.6.1.3 is not met as evidenced by: ent review and staff interview, been documenting sensitivity ke detectors on the fire alarm ince with NFPA 72 (99), Sec. ient practice could affect all 97	K 054	 The facility conducted and documented a smoke detector sensitivity test. The smoke detector sensitivity test wa completed on October 12th, 2016. The Director of Maintenance is responsible for scheduling smoke detector sensitivity tests in accordance 	

		E & MEDICAID SERVICES			1.000	0938-039 SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G 01 - MAIN BUILDING 01		PLETED
		245187	B, WING		09/	01/2016
AME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
TEXAS T	ERRACE CARE CEN	ITER		7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 054	Continued From pa	age 3	K 05	4 with the manufacturer's spe	cifications.	
	and 01:00 PM on S observation reveal	etween the hours of 09:00 AM September 01, 2016, ed that the facility could not ation of a current smoke test.				
K 056 SS=F	Administrator at th	tice was verified by the e time of inspection. AFETY CODE STANDARD	K 05	56		10/16/16
	facilities shall be p approved, supervis in accordance with systems are equip switches which are the building fire ala construction, alter shall be permitted protection in speci regulations prohib	e section 19.1.6, Health care rotected throughout by an sed automatic sprinkler system a section 9.7. Required sprinkler ped with water flow and tamper e electrically interconnected to arm. In Type I and II native protection measures to be substituted for sprinkler fic areas where State or local it sprinklers. 19.3.5, 19.3.5.1,				
	Based on observa automatic sprinkle maintained in accord Standard for the In 1999 edition. The system in complia	is not met as evidenced by: ations and staff interview, the r system is not installed and ordance with NAPA 13 the astallation of Sprinkler Systems failure to maintain the sprinkler nce with NAPA 13 (99) could		1. Upon review of document conjunction with Viking Auto Sprinkler Company, the fac quarterly reports on file but report. The facility spoke with Dan Archibald of Viking Auto	omatic ility had four no annual ith Inspector comatic	
	allow system bein decrease in the fir	g place out of service causing a e protection system capability in nergency that could affect all 97		Spinkler Company who rep Terrace is scheduled for an in quarter one of each year Spinkler Company sent a re 3/16/2016 that they did con annual inspection. 2. The facility was able to o	nual inspectior . Viking eport dated nplete an	

Event ID: XYMH21

Facility ID: 00144

If continuation sheet Page 4 of 6

		& MEDICAID SERVICES			O. 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ATE SURVEY OMPLETED	
		245187	B. WING		09/01/2016	
AME OF F	PROVIDER OR SUPPLIER		8	STREET ADDRESS, CITY, STATE, ZIP CODE		
EXAS T	ERRACE CARE CEN	TER		7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
K 056	observation revealed	September 01, 2016, ed that the facility could not ation for a current annual	K 056	reponsible to monitor and schedule all spinkler inspections.		
K 066 SS=D	Administrator at the NFPA 101 LIFE SA	tice was verified by e time of inspection . \FETY CODE STANDARD hs are adopted and include no ving provisions:	K 066		10/16/16	
	compartment when combustible gases and in any other ha area is posted with	hibited in any room, ward, or re flammable liquids, s, or oxygen is used or stored azardous location, and such n signs that read NO SMOKING ional symbol for no smoking.				
		tients classified as not nibited, except when under				
		ncombustible material and safe d in all areas where smoking is				
	devices into which readily available to permitted. 19.7. This STANDARD Based on observa staff interview, the policy for smoking	is not met as evidenced by: ations, document review and facility failed to follow the in accordance with NFPA LSC		1. For clarification, cigarrette butts wer discareded in a trash receptacle that is outside of the facility. The facility does allow smoking inside the facility at any		
	(00) Edition Sectio	n 1 <i>3.1.</i> 4.		time. However, the trash receptacle outside the back door of the facility is n	ot	

Event ID: XYMH21

Facility ID: 00144

If continuation sheet Page 5 of 6

		AND HUMAN SERVICES			FORM	APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE	E SURVEY PLETED		
		245187	B. WING		09/0	01/2016		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•			
TEXAS T	ERRACE CARE CEN	TER		7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE		
K 066	AM and 01:00 PM observation revealed butts discarded in a boiler room. This a smoking area.	age 5 between the hours of 09:00 on September 01, 2016, ed that there were cigarette a trash receptacle outside the rea was not a designated tice was verified by the e time of inspection.	K 066	a designated smoking area. The f has posted a memo reminding en of appropritate areas where smok allowed. The facility has also rem trash receptacle to relieve staff of tempation of discarding cigarette within trash can. The facility has a appropriate receptacles where en are permitted to smoke. 2. The memo, removal of garbage and addition of new cigarette rece occured on 10/14/2016. 3. The facility Director of Mainten- be responsible for monitoring tras receptacles and the facility Admin will be responsible for ensuring st smoking in permitted areas.	nployees ing oved the the butts added nployees e can, eptacles ance will h istrator			

Facility ID: 00144

If continuation sheet Page 6 of 6

PRINTED: 10/17/2016



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted September 23, 2016

Mr. Reid Hewitt, Administrator Texas Terrace Care Center 7900 West 28th Street Saint Louis Park, MN 55426

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5187025 and Complaint H5187072

Dear Mr. Hewitt:

The above facility was surveyed on August 28, 2016 through September 2, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5187072 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

Texas Terrace Care Center September 23, 2016 Page 2

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact **Gloria Derfus, Unit Supervisor at (651) 201-3792**.

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

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

Please feel free to call me with any questions.

Sincerely,

Kumala Fiske Downing

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

Minnesc	ota Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED
		00144	B. WING		09/0	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TEXAS 1	ERRACE CARE CEN	IFR	ST 28TH STR UIS PARK, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 09/30/16

Electronically Signed

6899

If continuation sheet 1 of 49

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED		
		00144	B. WING		09/	09/02/2016		
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE	•			
TEXAS TERRACE CARE CENTER 7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE		
2 000	Department of Hea you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th corrected prior to e Minnesota Departm On 9/2/16, surveyo visited the above pi correction orders a your electronic plar reviewed these ord they will be comple Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag m column entitled "ID statute/rule out of o "Summary Stateme and replaces the "T correction order. Th	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. rs of this Department's staff, rovider and the following re issued. Please indicate in n of correction that you have ers, and identify the date wher						
	are the Suggested Time period for Con PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	wing the surveyors findings Method of Correction and rrection. ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.						

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION ()	(3) DATE SURVEY COMPLETED	
		00144	B. WING		09/02/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TEXAS 1	ERRACE CARE CEN	TER	T 28TH STF UIS PARK, I			
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2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC MINNESOTA STAT	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES. stigation of complaint, npleted. The complaint was				
2 255	MN Rule 4658.0070 Assurance Commit	0 Quality Assessment and tee	2 255		10/12/1	
	assessment and as of the administrator services, the medic designated by the medic designated by the medic three other membe representing disciple resident care. The assurance committer respect to which que necessary and deve appropriate plans of quality deficiencies, address, at a minimedication	ist maintain a quality surance committee consisting t, the director of nursing al director or other physician nedical director, and at least rs of the nursing home's staff, lines directly involved in quality assessment and ee must identify issues with lality assurance activities are elop and implement f action to correct identified . The committee must num, incident and accident control, and medications and				
	by: Based on interview facility failed to ensi- recognized and dev address an identifie to smoking for 5 of R118, R177) identif while smoking. In a	ent is not met as evidenced and document review, the ure the quality committee (QC) veloped an action plan to ed lack of supervision related 7 residents (R16, R95, R101, ied as needing supervision ddition the facility failed to icces in the areas of abuse		Corrected.		

	T OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING			
		00144			09/	02/2016
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S ⁻ S T 28TH STRI			
EXAS T	ERRACE CARE CEN	11 F R	OUIS PARK, M			
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2 255	Continued From pa	age 3	2 255			
	control that were ic recertification surve	sary medications and infection dentified in a previous ey on 9/17/15. These practices o affect all 101 residents in the				
	Findings include:					
	adequate supervisi R95, R101, R118,	facility failed to provide ion for 5 of 7 residents (R16, R177) who were identified as ave the facility unsupervised to				
	executive director of a physician's order facility unsupervise the sidewalk in from stated the resident smoking materials there was currently smoking materials the building. The E assessed as safe t smoke during allott smoking area outs further stated he w did not have an ord	v on 8/31/16, at 8:38 a.m. the (ED) stated residents who had allowing them to leave the ed were allowed to stand out or nt of the facility to smoke. He s were to sign out their before going outside, however y no plan in place to check the when the residents returned to ED stated for residents not to smoke unsupervised could ted times in the supervised ide the lower level. The ED vas aware some residents who der to leave the facility had oking on the sidewalk ng the survey.	,			
	immediately report designated State a accordance with fa	F226: the facility failed to allegations of abuse to the gency (SA) as required and in acility policy for 4 of 5 residents 75) who alleged mistreatment				
	Refer to F329: The	e facility failed to implement				

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TEXAS T	ERRACE CARE CEN	IFR	ST 28TH STR DUIS PARK, M			
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2 255	Continued From pa	ge 4	2 255			
	appropriate monitor medications.	ring for the use of psychotropic	;			
	appropriate infectio	facility failed to implement n control measures to reduce during wound care.				
	A facility policy regarded requested but none	arding quality assurance was was received.				
	quality committee c identifying quality d issues are identified	HOD OF CORRECTION: The ould review their system for eficiencies to ensure systems d and addressed. The ack progress to ensure ms.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 300	MN Rule 4658.010	5 Competency	2 300			10/12/10
	are able to demons techniques necessaneeds, as identified resident assessment	ist ensure that direct care staff trate competency in skills and ary to care for residents' I through the comprehensive nts and described in the n of care, and are able to ned duties.				
	by: Based on interview facility failed to ens (NAs) had complete a valid testing agen	ent is not met as evidenced and document review, the ure all nursing assistants ed a competency testing from icy as required. This had the 0 residents on 1st floor and		Corrected		

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NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
TEXAS T	ERRACE CARE CEN	TER	ST 28TH STR				
		SAINT LO	DUIS PARK, M				
		Y EMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 300	Continued From pa	age 5	2 300				
	Findings include:						
	Department of Hea for 569 NAs for per tested to become fe included the Inver H Center for Professi Development and it Online in West St. I and October 16, 20 investigators found results associated of questions about the Although it was unc took the tests at the period of May 2014	clear which individuals who e two locations during the time to October 2015 may have					
	been impacted by t MDH took precaution individuals tested a that timeframe, with	he potential improprieties, ons requiring re-testing for all t those two locations during nout cost to the individuals. continue to work, however,					
	were required to re 2016. Any individua re-testing by that da ineligible to work as nursing home or bo addition, many state	-test no later than March 31, als who did not pass the ate would be considered is a NA at a federally certified bard and care home. In e licensed employers chose als who had not passed the					
	centers listed above 12/15, stating re-tes by 3/31/16. NA-A w nursing home until	npetency from one of the e. A letter was sent to NA-A in sting needed to be completed ras not eligible to work in the the tests were passed, and the anged on Minnesota's NA /1/16.					

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2 300	Continued From pa	ige 6	2 300			
	completed re-testin on the NA Registry facility after inactive 8/19/16. NA-A work and was scheduled facility staff reporte from the schedule f During an interview human resources of informed the NAs w	o verify all NAs affected had g as required, and were active NA-A continued to work in the e status from 4/1/16 through ted in the facility on 9/1/16, to work again on 9/2/16. The d NA-A would be removed for 9/2/16, at 9:11 a.m. the lirector stated she had who met the re-testing should have also verified				
	NA-A's status on the SUGGESTED MET director of nursing of devise a NA Regist on the Registry wou could be conducted quality committee for	THOD OF CORRECTION: The or human resources staff could ry verification system. Staff no uld not be scheduled. Audits and the result brought to the	k			
2 560	Plan of Care; Contents Subp. 2. Contents comprehensive pla objectives and time long- and short-terr and mental and psy identified in the con assessment. The c must include the inc	of plan of care. The n of care must list measurable stables to meet the resident's m goals for medical, nursing, ychosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557,				10/12/16

Minneso	ta Department of He	alth				
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2 560	Continued From pa	ge 7	2 560			
	by: Based on observati review the facility fa 1 of 2 residents (RS for alcohol intoxicat illegal substances in	ent is not met as evidenced on, interview and document illed to develop a care plan for 95) who had been hospitalized ion and was known to use n the facility.		corrected		
	Findings include:					
	Review of R95's me included the followi	edical record progress notes ng:				
	[social worker] was found in a room roll	e dated 6/6/16, indicated, "SW informed that resident was ing marijuana as cigs ng/Drugs policy was reviewed				
	was hosp. for BS de blood sugar due to	e dated 6/7/16 read, "Resident ue to ETOH[hospitalized for alcohol] abuse. SW disposed nk and a room search was				
	6/7/16 included R98 emergency room to unresponsiveness a reading. Written in a	orm and progress note dated 5 was sent to the hospital 6 evaluate and treat and an elevated blood sugar above the R95's name ng "[R95] was smoking pot				
diagonale D	R95 was incoheren blood sugar of 533. was called and prov [immediate] 10 unit	d 6/7/16 at 3:30 p.m. included t and unresponsive with a R95's nurse practitioner (NP) vided an order for STAT s of Novalog insulin and to ency room for an evaluation.				

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TEXAS T	ERRACE CARE CEN	ITER	EST 28TH STRI OUIS PARK, M			
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2 560	Continued From pa	age 8	2 560			
	indicated the residu hyperglycemia and returned five hours A social service no "Resident's care pl reviewed with social guardian and residu use over the week using and reported not to repeat this b	disciplinary team note ent was hospitalized 6/7/16 for alcohol intoxication. R95 blater with no new orders. te dated 6/25/16, read an and assessments were al worker, community police, lent. Review of the THC [drug] end. Resident admitted to I the source. Resident agreed behavior". A psychology referra the licensed social worker				
	was "seen smoking an illegal substance a trained medication smoking are and s residents were app substance was ma apologized to staff pass it to one anot nothing found, she	ted 6/26/16 at 3:00 p.m. R95 g with another resident [R118] e. The nurse accompanied by on aide came out to the melled the substance. The proached and asked if the arijuana. The residents for smoking it but continued to her. [R95] was searched and had no pockets and stated, R95's NP and the director of ed.				
	hospitalization for a 6/25/16 use of mar	not include the 6/7/16 alcohol use or the 6/6/16 and rijuana. R95's cognitive testing e resident had moderate ent.	1			
	executive director clinical services (D plan did not identify	I/16 at 9:14 a.m. with the ED, DON and director of (CS) confirmed that the care y R95's alcohol or drug use in t is should have been included				

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2 560	Continued From pa	age 9	2 560				
	on the careplan.						
	On 9/2/16, at 8:45 requested but was	a.m. the care plan policy was not provided.					
	director of nursing policies. Education provided. Audits co	THOD OF CORRECTION: The or desginee could review of appropriate staff could be ould be conducted and the he quality committee for					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one					
2 570	MN Rule 4658.040 Plan of Care; Revis	5 Subp. 4 Comprehensive sion	2 570			10/12/16	
	care must be review interdisciplinary tea physician, a register for the resident, an disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within	A comprehensive plan of wed and revised by an am that includes the attending ered nurse with responsibility d other appropriate staff in rmined by the resident's needs practicable, with the resident, the resident's legal n representative at least n seven days of the revision of e resident assessment required subpart 3, item B.					
	by: Based on observat review the facility fa include the need fo 2 of 7 residents (RS	ent is not met as evidenced ion, interview and document ailed to revise care plans to or supervision with smoking for 95, R117) who required noking, and a careplan for 1 of		Corrected			

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2 570	Continued From pa	ige 10	2 570				
	illegal substances. update and revise t	identified to possess and use In addition, the facility failed to he careplan for weight loss ntal status for 1 of 3 (R106) t loss.					
	Findings include:						
	indicating moderate entrance conference	e assessment dated 7/1/16, e cognitive impairment. During e on 8/29/16, at 8:04 a.m. the 95 required supervision with					
	R95 as independer careplan dated 7/1	nent dated 3/31/16, identified htly able to smoke. R95's 5, identified R95 smoked, clude if supervision was					
	smoking on the Ga supervised smoking hours. The surveyo (RN)-A whether the	0 a.m. R95 was observed rden Terrace patio (approved g area) during non-smoking or asked registered nurse e resident was supposed to be io. RN-A replied "no" and into the building.					
	wheeled outside to	m. R95 independently the front of the facility, sat in and smoked a cigarette, and building.					
	sitting outside on th smoking a cigarette supervising the smo elevator R95's cloth covered with cigare	p.m. R95 was observed the Garden Terrace patio e. No staff was observed to be oking. At 7:37 p.m. in the ning and wheelchair were ette ashes. There was a hole the wheelchair attached that					

(EACH DEFICIENC REGULATORY OR also filled with iew of R95's m uded the follow ocial service no rmed resident is for smokers ervised. Reside agreed to the out to go inde s out."	ATEMENT OF DEFICIENCIES EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) age 11 a ash. medical record progress note	SW	REET	OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE	02/2016 (X5) COMPLET DATE
ACE CARE CEN SUMMARY ST (EACH DEFICIENC REGULATORY OR tinued From p also filled with iew of R95's m uded the follow ocial service no rmed resident is for smokers ervised. Reside agreed to the out to go inde s out."	TER 7900 SAIN ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) age 11 ash. hedical record progress note ring: bt dated 8/1/16 identified "St that there will be scheduled to go to the patio to smoke ent signed the smoking polic rules. Resident is also able pendently to smoke if she bt dated 8/2/16 noted "The	WEST 28TH STR T LOUIS PARK, M PREFIX TAG 2 570 SW	REET MN 55426 PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T	ACTION SHOULD BE	COMPLET
SUMMARY ST (EACH DEFICIENC REGULATORY OR tinued From p also filled with iew of R95's m uded the follow pocial service no rmed resident s for smokers ervised. Reside agreed to the out to go inde s out."	ATEMENT OF DEFICIENCIES ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) age 11 a ash. hedical record progress note ing: but dated 8/1/16 identified "S that there will be scheduled to go to the patio to smoke ent signed the smoking polic rules. Resident is also able pendently to smoke if she but dated 8/2/16 noted "The	T LOUIS PARK, N ID PREFIX TAG 2 570 SW Cy	MN 55426 PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T	ACTION SHOULD BE	COMPLET
(EACH DEFICIENC REGULATORY OR also filled with iew of R95's m uded the follow ocial service no rmed resident is for smokers ervised. Reside agreed to the out to go inde s out."	age 11 age 11 ash. hedical record progress note ing: the dated 8/1/16 identified "S that there will be scheduled to go to the patio to smoke ent signed the smoking polic rules. Resident is also able pendently to smoke if she	2 570 es SW	(EACH CORRECTIVE A CROSS-REFERENCED T	ACTION SHOULD BE	COMPLET
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rmed resident es for smokers ervised. Reside agreed to the out to go inde s out."	that there will be scheduled to go to the patio to smoke ent signed the smoking polic rules. Resident is also able pendently to smoke if she ote dated 8/2/16 noted "The	су			
ember or com ed guardian wh oke 'only' during oosted on each	oly with staff requests. SW to agrees to allow resident to g supervised scheduled time unit. The resident and staf he restriction and changeh	es f			
cated R95 was -smoking hour		ent.			
8/31/16, at 10:4 to smoke whi ng smoking tin	2 a.m. confirmed R95 was le supervised on the patio nes and her smoking materi	only			
N)-C on 8/31/1 ked and requi	6, at 11:07 a.m. confirmed F red staff supervision and tha				
	smoking hour rette that she in hterview with li /31/16, at 10:4 to smoke whing smoking tim uld have been hterview with li N)-C on 8/31/1 ked and requir moking materi king cart.	smoking hours. R95 smoked another rette that she received from another reside hterview with licensed social worker (LSW /31/16, at 10:42 a.m. confirmed R95 was to smoke while supervised on the patio ng smoking times and her smoking material and have been locked in the smoking cart. hterview with licensed practical nurse N)-C on 8/31/16, at 11:07 a.m. confirmed F ked and required staff supervision and that moking materials were to be kept in the king cart.	smoking hours. R95 smoked another rette that she received from another resident. hterview with licensed social worker (LSW)-A /31/16, at 10:42 a.m. confirmed R95 was only to smoke while supervised on the patio ng smoking times and her smoking materials and have been locked in the smoking cart. hterview with licensed practical nurse N)-C on 8/31/16, at 11:07 a.m. confirmed R95 ked and required staff supervision and that moking materials were to be kept in the king cart.	smoking hours. R95 smoked another rette that she received from another resident. hterview with licensed social worker (LSW)-A /31/16, at 10:42 a.m. confirmed R95 was only to smoke while supervised on the patio ng smoking times and her smoking materials and have been locked in the smoking cart. hterview with licensed practical nurse N)-C on 8/31/16, at 11:07 a.m. confirmed R95 ked and required staff supervision and that moking materials were to be kept in the king cart.	smoking hours. R95 smoked another rette that she received from another resident. hterview with licensed social worker (LSW)-A /31/16, at 10:42 a.m. confirmed R95 was only to smoke while supervised on the patio ng smoking times and her smoking materials uld have been locked in the smoking cart. hterview with licensed practical nurse N)-C on 8/31/16, at 11:07 a.m. confirmed R95 ked and required staff supervision and that moking materials were to be kept in the

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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
EXAS T	ERRACE CARE CEN	TER	ST 28TH STRI OUIS PARK, M			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO	THE APPROPRIATE	DATE
2 570	Continued From pa	age 12	2 570			
		dent who smoked. A smoking 8/11/16, indicated R177 ked.				
	resident as alert an smoked. Intervention materials were to b	ated 8/15/16, identified the ad oriented and someone who ons included smoking be kept in the smoking cart, dicate whether R177 required noking.				
	and stated that he independently and R177 stated he sig returned as he des	ved on 8/30/16, at 2:45 p.m. was able to smoke kept his cigarettes in his room ned out to smoke and left and ired. R177 stated he did not go ke because smoke times were				
		P.m. R177 was independently ewalk outside the facility.	/			
	of RN-A and LSW-	5 p.m. R177 was hear inquiring C, why he had "to go outside e suddenwhy now?"				
	about smoking at tl	9 p.m. R177 was interviewed he facility and stated "I can't go took my cigarettes and I can't				
	regarding R177 sm stated that smoking up and whomever responsible to know smoking and who	5 a.m. LSW-C was interviewed noking unsupervised. LSW-C g materials were kept locked passed out the materials was w who required supervision for was allowed to smoke				
	R177 had been kee	en asked if she was aware eping his own cigarettes she bt that he keeps his cigarettes				

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			E SURVEY PLETED	
	00144	B. WING	B. WING		09/02/2016	
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ERRACE CARE CEN						
(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
Continued From pa	age 13	2 570				
on him" and confirmed R177's smoking materials had been confiscated on 8/31/16.						
R177's and R95's of supervision with sn	careplan did not include noking and that it should have					
9/1/16, at 9:14 a.m	. and stated she would expect					
indicated R39 adm cognition assessme	itted to the facility in 4/16. A ent dated 7/13/16 identified					
been caught smoki pain relief-knows it Practitioner] aware suspected/witness address or identify	ing marijuana-states it's for 's illegal. NP [Nurse - hold all narcotics if pot ed." The careplan did not further interventions on what					
and director of clini interviewed on 9/1/ R118's careplan wa direct staff to call p	ical services (DCS) were (16, at 9:14 a.m. and stated as poorly written and did not olice or complete a room					
R106 had diagnose disorder. R106 nee	es including anemia and mood eded set up at meals, was					
	OF CORRECTION PROVIDER OR SUPPLIER ERRACE CARE CEN SUMMARY ST/ (EACH DEFICIENC REGULATORY OR I Continued From pa on him" and confirr had been confiscat On 8/31/16, at 11:0 R177's and R95's of supervision with sr been included on th The director of nur 9/1/16, at 9:14 a.m care plans to include for smoking. R118's admission f indicated R39 adm cognition assessm R118 had moderat R118's careplan da been caught smok pain relief-knows it Practitioner] aware suspected/witness address or identify to do when in quest The executive direct and director of clini- interviewed on 9/1/ R118's careplan was direct staff to call p search when subst R106's quarterly M R106 had diagnose disorder. R106 nee- independent with e	OF CORRECTION IDENTIFICATION NUMBER: 00144 00144 PROVIDER OR SUPPLIER STREET A FERACE CARE CENTER 7900 WE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 On him" and confirmed R177's smoking materials had been confiscated on 8/31/16. On 8/31/16, at 11:07 a.m. LPN-B confirmed R177's and R95's careplan did not include supervision with smoking and that it should have been included on the careplan. The director of nursing (DON) was interviewed or 9/1/16, at 9:14 a.m. and stated she would expect care plans to include if supervision was required for smoking. R118's admission face sheet was reviewed and indicated R39 admitted to the facility in 4/16. A cognition assessment dated 7/13/16 identified R118 had moderate cognitive impairment. R118's careplan dated 7/16 identified R118 "has been caught smoking marijuana-states it's for pain relief-knows it's illegal. NP [Nurse Practitioner] aware- hold all narcotics if pot suspected/witnessed." The careplan did not address or identify further interventions on what to do when in question of drug use. The executive director, director of nursing (DON) and director of clinical services (DCS) were interviewed on 9/1/16, at 9:14 a.m. and stated R118's careplan was poorly written and did not direct staff to call police or complete a room search when substance use was suspected. R106's quarterly MDS dated 7/16/16, indicated R106 had diagnoses including anemia and mood disorder. R106 needed set up at meals, was inde	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00144 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATEMENT OF DEFICIENCIES RERACE CARE CENTER 7900 WEST 28TH STRISAINT LOUIS PARK, M SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 13 2 570 on him" and confirmed R177's smoking materials had been confiscated on 8/31/16. ID ON 8/31/16, at 11:07 a.m. LPN-B confirmed R177's and R95's careplan did not include supervision with smoking and that it should have been included on the careplan. 2 570 The director of nursing (DON) was interviewed on 9/1/16, at 9:14 a.m. and stated she would expect care plans to include if supervision was required for smoking. 1 R118's admission face sheet was reviewed and indicated R39 admitted to the facility in 4/16. A cognition assessment dated 7/13/16 identified R118 had moderate cognitive impairment. 1 R118's careplan dated 7/16 identified R118 "has been caught smoking marijuana-states it's for pain relief-knows it's illegal. NP [Nurse Practitioner] aware- hold all narcotics if pot suspected/witnessed." The careplan did not address or identify further interventions on what to do when in question of drug use. The executive director, director of nursing (DON) and director of clinical services (DCS) were interviewed on 9/1/16, at 9:14 a.m. and stated R118's careplan was poorly wr	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00144 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ERRACE CARE CENTER 7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREPIX (EACH CORRECTIVE AC) (EACH CORRECTIVE AC)	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COM 00144 B. WING 09/ PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE FRACE CARE CENTER 7900 WEST 28TH STREET SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID REGULATORY ON LSC IDECEDED BY FULL PRECENCE TO THE APPROPRIATE Continued From page 13 CROSS-REFERENCED TO THE APPROPRIATE Do him" and confirmed R1775 smoking materials had been confiscated on 8/31/16. 2570 On 8/31/16, at 11:07 a.m. LPN-B confirmed R177's and R95's careplan did not include supervision was required for smoking. The director of nursing (DON) was interviewed on 9/11/6, at 9:14 a.m. and stated she would expect care plans to include if supervision was required for smoking. R118's admission face sheet was reviewed and indicated R39 admitted to the facility in 4/16. A cognition assessment dated 7/13/16 identified R118 "has been caupt smoking endures it's for pain relief-knows it's illegal. NP [Nurse Practitioner] aware- hold all narcotics if pot suspected/intersed. The careplan did not did not did did not directs of nursing (DON) and director of nursing of (DON) and director of nursing of (DON) and director of nursing of (DON) and director of nursing and that a mad stated she would expect care interviewed on 9/11/6, at 1:1 The executive director, director of nursing (DON) and director of clinicial services (DCS) were interviewed on 9/	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00144	B. WING		09/	02/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	ITER	EST 28TH STRI JOUIS PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From page 14		2 570			
	prior and the curre The assessment d	ighed 159 pounds 30 days nt weight was not available. id not address the weight loss to reduce the risk of weight				
	weights were: - 8/30/16, 148 lbs. - 7/16, no weights :	available (11 lbs or a 7.4% loss)				
	8/8/16, indicated R 26 teeth removed a bleeding secondar warfarin (a blood th	oner progress note dated 106 had dental surgery, had and had a complication of y to anticoagulant therapy on ninner). Additionally, R106 was 3/8/16, to 8/11/16 due to cooth extraction.	5			
	on his own, would stare straight ahea R106 and he drank had pushed half of	D p.m., R106 was slowly eating stop for several minutes and d. At 7:09 p.m. staff offered better out of the glass. R106 the food off the regular plate sked the nurse manager about e.				
	breakfast, had a tw cereal in a bowl an assistance was pro	D a.m. R106 was served vo-handled cup with a straw, id a regular plate. No staff ovided with eating. The dietary vided plate with raised sides provided for R106.	,			
	stated cards for ea	0 a.m. dietary staff (DS)-A uch person with assistive ue cart, but were not always				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00144	B. WING	3. WING		09/02/2016	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
EXAS T	ERRACE CARE CEN	IFR	ST 28TH STRE DUIS PARK, M				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 570	Continued From pa	age 15	2 570				
	accurate.						
	have weight loss as R106's tooth extract include the adaptiv noted R106 was inc	e plan dated 7/21/16, did not s a concern and did not identify ctions. The care plan did not e equipment for eating, and dependent with eating.	,				
	on 9/1/16, at 12:20 would be updated b	p.m. she stated the care plan by nursing for oral surgeries. bounds had not been brought					
	On 9/2/16, at 8:45 was requested but	a.m. the care planning policy was not provided.					
	director of nursing policies. Education provided. Audits co	THOD OF CORRECTION: The or desginee could review of appropriate staff could be ould be conducted and the he quality committee for					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one					
2 965	MN Rule 4658.060 -Nutritional Status	0 Subp. 2 Dietary Service	2 965			10/12/1	
	must ensure that a which supplies the determined by the assessment. Subs	onal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident titutes of similar nutritive value residents who refuse food					

6899

Minnesc	ta Department of He	alth				
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00144	B. WING		09/0	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	IFR	ST 28TH STF OUIS PARK, I			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 965	Continued From pa	ge 16	2 965			
	by: Based on observati review, the facility f parameters of body (R16, R106) review Findings include: R16 reported on 8/3 resided at the facilit R16 explained that not let him eat and "I eat and drink whe supposed to get me aspiration pneumor R16's nutrition care R16 was nutritional disease, and was a secondary to diabe "weight will remain directed staff to pro by mouth (NPO), su weights monitored a The nutrition progre- indicated R16 was tube feeding tolerar Nutrition note dated was not meeting the hydration secondar himself from the tut day to smoke. Resi	ent is not met as evidenced on, interview and document ailed to maintain acceptable weight for 2 of 3 residents ed for weight loss. 30/16, at 7:28 p.m. he had cy since the previous winter. the speech therapist would he was fed via a tube feeding. en I get a chance. They are e in for a swallow study. I had hia and was at the hospital." I plan dated 4/4/16, indicated ly at risk related to cardiac t risk for dehydration tes type II. Care plan goal was stable +/-3%." Care plan vide diet as ordered, nothing upplements were ordered and as needed (PRN) per protocol. ess note dated 4/8/16, to be followed up monthly for nce and weight stability. 4/14/16, indicated resident e estimated nutrition and y to resident discontinuing be feeding pump during the dent had agreed to change is to help ease compliance of		Corrected		
		mpleted 7/18/16, indicated weight in July and continued				

STATEMEN	DIA Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00144	B. WING		09/02/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
TEXAS T	FERRACE CARE CEN	ITER	ST 28TH STRI DUIS PARK, M			
(X4) ID PREFIX TAG			TION SHOULD BE	(X5) COMPLET DATE		
2 965	Continued From pa	age 17	2 965			
	on bolus tube feeding four times daily. However, it did not indicate risk and benefits had been reviewed with R16.					
	dated 4/18/16, indi	e Area Assessment (CAA) cated the resident had have nothing by mouth and ings.				
	diabetes type II ob Minimum Data Set addition the MDS i feedings, and "No percent (%) or more	tained from the quarterly (MDS) dated 7/8/16. In ndicated R16 received tube or unknown" for loss of five re in the last month or loss of st six months with no weights				
	-R16 had no condi may result in a life months -Was not on a plar -Had a 18 pounds closest weight to s re-admission weigh	eview it was revealed: tion or chronic disease that expectancy of less than 6 aned weight loss program (lbs) weight loss between the survey and most recent ht which was a 9.7% weight				
	revealed no weight	s 202.0 lbs as 202.6 lbs				
nnesota D	-June 2016 no wei -7/7/16, refused we -8/30/16, weight wa	ghts obtained				

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED		
		00144	B. WING		09/	02/2016		
	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE				
		7900 WE	ST 28TH STRE	ET				
TEXAS TERRACE CARE CENTER SAINT LOUIS PARK, MN 55426								
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
2 965	Continued From pa	lge 18	2 965					
	registered dietitian been a struggle get about the multiple r record. The RD sta assessments witho document weights The RD stated she in 4/16. The RD ind about the weight iss including the execu of nursing on about stated "I need other board so we can ge acknowledged nutri MDS's were not acc unavailable. On 8/30/16, at 11:4	ut weights and had to were not obtained or refused. started working at the facility licated she had sent e-mails sues weekly to corporate, itive director (ED) and director t the issue. The RD further r departments to jump on et this issue resolved." The RD itional assessments and curate because weights were 4 a.m. licensed practical nurse						
	obtaining the weigh	had two months when Its had been successful, ome a problem again and they September.						
	know why R16 had asked why a swallo completed, the RD the 'trach people' a never be removed transitional care un	o.m. the RD stated she did not a gastrostomy tube. When wing study had not been replied, "I believe he went to nd was told his trach would when [R16] was in the it [TCU]." When asked if R16's ed to be monitored monthly,						
	the RD stated "I wo RD acknowledged a residents was learn balancing her time	buld like to keep up with it." The a hindrance to monitoring hing the new role and between two facilities. The RD bably noticed the missing						

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00144	0144 B. WING		09/	09/02/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	r ADDRESS, CITY, STATE, ZIP CODE				
TEXAS T	ERRACE CARE CEN	ITER	ST 28TH STRE				
0(0) 15			OUIS PARK, M	N 55426 PROVIDER'S PLAN OF			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 965	Continued From pa	age 19	2 965				
	stated the resident "fell through the cracks."						
	RD stated she sho weight loss betwee weights. The RD si the nurse documer provider her with u R16 was at a high would have re-eval since she had iden On 9/1/16, at 4:10 (NP) stated she wo monitor R16's weig risk for nutritional is and refusing tube f received a call from facility indicating R out and the facility brand. The NP stat tube feeding order	6 had sustained a weight loss uld have been notified of the en the 4/11/16, and 8/30/16, tated she would have expected noting the weight to have pdates. The RD further stated risk for malnutrition and she luated the current interventions tified the 9.7% weight loss. p.m. the nurse practitioner buld have expected the RD to ghts closely due to R16's high ssues because of the diabetes eeding. The NP stated she had n one of the nurses at the 16's tube feeding type had run needed an order for a different ted prior to giving the recent she had requested R16 to be as told the RD had not seen	; d				
	7/15, indicated the review/evaluate ch weight loss, discus with nursing staff s recommend chang to improve/stabilize monitor the interve educate the reside each assessment a	anges in conditions such as is intolerance and/or concerns uch as weight loss, les to the physician as needed e resident nutritional status, ntions and effectiveness and to nt and family as needed during					
	diagnoses includin R106 needed set u	g anemia and a mood disorder up at meals, was independent ud no weight loss issues.					

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUF ND PLAN OF CORRECTION IDENTIFICATION		A. BUILDING: _		COM	E SURVEY PLETED
	00144	B. WING		09/	02/2016
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ERRACE CARE CEN	ITER				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Continued From pa	age 20	2 965			
R106's Nutrition Risk Assessment dated 7/27/16, indicated R106 weighed 159 pounds 30 days ago, and the current weight was not available. The assessment did not address the weight loss with interventions to reduce the risk of weight loss.					
weights were: - 8/30/16, 148 lbs. - No weights availa - 6/21/16, 159 lbs.	(pounds) Ible in 7/16 (11 lbs or a 7.4% loss)				
8/8/16, indicated R 26 teeth removed a bleeding secondar warfarin (a blood th hospitalized from 8	106 had dental surgery, had and had a complication of y to anticoagulant therapy on hinner). Additionally, R106 was //8/16, to 8/11/16 due to				
on his own, would stare straight ahea R106 a straw and I R106 had pushed plate and R106's w	stop for several minutes and d. At 7:09 p.m. staff offered he drank better out of a glass. half of the food off the regular vife asked the nurse manager				
breakfast, had a 2 in a bowl and a reg was provided with indicated a divided	handle cup with a straw, cerea jular plate. No staff assistance eating. The dietary card plate with raised sides should				
	ERRACE CARE CEN SUMMARY ST/ (EACH DEFICIENC REGULATORY OR I Continued From pa R106's Nutrition Ri indicated R106 we ago, and the current The assessment d with interventions t loss. Review of the med weights were: - 8/30/16, 148 lbs. - No weights availa - 6/21/16, 159 lbs. - No weights availa - 4/1/16, 167 lbs. The nurse practition 8/8/16, indicated R 26 teeth removed a bleeding secondar warfarin (a blood th hospitalized from 8 bleeding from the t On 8/30/16, at 6:40 on his own, would stare straight ahea R106 a straw and I R106 had pushed plate and R106's w about using a lippe On 8/31/16, at 8:00 breakfast, had a 2 in a bowl and a reg was provided with indicated a divided	PROVIDER OR SUPPLIER STREET A PRACE CARE CENTER 7900 WE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 R106's Nutrition Risk Assessment dated 7/27/16, indicated R106 weighed 159 pounds 30 days ago, and the current weight was not available. The assessment did not address the weight loss with interventions to reduce the risk of weight loss. Review of the medical record indicated the weights were: - 8/30/16, 148 lbs. (pounds) - No weights available in 7/16 - 6/21/16, 159 lbs. (11 lbs or a 7.4% loss) - No weights available in 5/16 - 4/1/16, 167 lbs. The nurse practitioner progress note dated 8/8/16, indicated R106 had dental surgery, had 26 teeth removed and had a complication of bleeding secondary to anticoagulant therapy on warfarin (a blood thinner). Additionally, R106 was hospitalized from 8/8/16, to 8/11/16 due to bleeding from the tooth extraction. On 8/30/16, at 6:40 p.m., R106 was slowly eating on his own, would stop for several minutes and stare straight ahead. At 7:09 p.m. staff offered R106 a straw and he drank better out of a glass. R106 had pushed half of the food off the regular plate and R106's wife asked the nurse manager about using a lipped plate for R106. On 8/31/16, at 8:00 a.m. R106 was served breakfast, had a 2 handle cup with a straw, cereat in a bowl and a regular plate. No staff assistance was provided with eating. The dietary card	Construction Street Address, City, Street, Street, Address, City, Street, Street, Address, Street Address, Street Address, Street Address, Street Address, Street Address, Street Address, Street, Stree	PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ERRACE CARE CENTER 7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426 SUMMARY STATEMENT OF DEFICIENCIES (EACH OPERICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF (EACH OPERICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF (EACH OPERICIENCIES CONTINUED THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF (EACH OPERICED TO T DEFICIENCE DOE Continued From page 20 2 965 2 965 PREFIX TAG PREFIX (EACH OPERICED TO T DEFICIENCE DOE Continued From page 20 2 965 2 965 PREFIX TAG PREFIX (EACH OPERICED TO T DEFICIENCE Continued From page 20 2 965 PREFIX TAG PREFIX (EACH OPERICED TO T DEFICIENCE PREFIX TAG Continued From page 20 2 965 PREFIX The assessment did not address the weight loss with interventions to reduce the risk of weight loss. PREFIX (FIG TAG TAG TAG TAG TAG TAG TAG TAG TAG TA	Image: Construction of the second s

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00144	B. WING		09/	02/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
TEXAS 1	ERRACE CARE CEN	ITER	ST 28TH STR OUIS PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 965	Continued From pa	age 21	2 965			
		ated cards for each person with assistive evices are on the cart, but were not always ecurate.				
	weights had been of asked for weights to assessments and the weight for R100 address weight los asked for a reweig accurate. She state not a normal part of equipment would be a resident attended of 148 lbs. had not The RD stated the been addressed in R106's current car have weight loss a R106's tooth extrate include the adaptive	D p.m. the RD stated obtaining on ongoing issue. She had to complete nutrition not received them. Regarding 6, the assessment did not is. If it had, she would have h and assured the loss was ed that meal observations were of the assessment. Adaptive be recommended by therapy if d. The weight loss and weight been brought to her attention. oral surgeries would have the care plan by nursing. e plan dated 7/21/16, did not s a concern and did not identify ctions. The care plan did not re equipment for eating, and idependent with eating.				
	when significant we interdisciplinary tea interventions base cause of weight los	Weight Loss policy indicated eight loss was identified the am would determine d on the resident's individual ss and these interventions were resident's care plan.	9			
	registered dietitian experienced or had Education of appro Audits could be co	THOD OF CORRECTION: The could review residents who d potential for weight loss. opriate staff could be provided. nducted and the results lity committee for review.	•			
innesota D	brought to the qual					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00144	B. WING		- 09/02/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	TER	ST 28TH STRE OUIS PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
2 965	Continued From pa	ge 22	2 965			
	(21) days.					
21390	MN Rule 4658.0800) Subp. 4 A-I Infection Control	21390			10/12/1
	control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service ed prevention and con E. a resident he immunization progr defined in part 465 procedures of resid the prevention and F. the developr employee health po practices, including defined in part 4658 G. a system for H. a system for products which affe disinfectants, antise incontinence produce	ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; nent and implementation of licies and infection control a tuberculosis program as 8.0815; r reviewing antibiotic use; r review and evaluation of ct infection control, such as eptics, gloves, and				
	by: Based on interview facility failed to imp	and document review, the ement a policy and procedure occal conjugate vaccine		corrected		

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00144	B. WING		09/	02/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	TER	ST 28TH STR OUIS PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From pa	ige 23	21390			
	(PCV13) for 1 of 5 vaccination historie	residents (R64) whose s were reviewed.				
	Findings include:					
	identified "Adults 68 have not previously have previously rec PPSV23 (pneumoc 23) should receive PCV13 should be a after the most rece R64's Immunization indicated the 79 yea Pneumovax in 2007 had been offered th admission to the fa On 9/02/2016, at 83 (DON) was intervie guidelines for upda had been implement	n record, dated 7/28/09 ar old resident received the 7, there was no evidence he ne PCV13 vaccine since his				
	adults 65 years of a PCV13 followed by	ated 7/16 indicated that "All age or older receive a dose of a dose of pneumococcal cine [PPSV23] at least 1 year				
	director of nursing a could review immun to determine wheth offered. Residents be educated as to t	THOD OF CORRECTION: The and/or infection control nurse nization status for all residents er vaccination should be who decline vaccination could the risks and benefits, and if ues to decline, document in the				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00144	B. WING		09/	02/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	TER	ST 28TH STF DUIS PARK, I			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21390	Continued From pa	age 24	21390			
		ation record. Audits could be results brought to the quality ew.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426			10/12/16
	maintain a compre- infection control pro- current tuberculosis issued by the Unite Control and Prever Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding impleme	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines ed States Centers for Disease ntion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). t include a tuberculosis an that covers all paid and contractors, students, inteers. The Department of e technical assistance ntation of the guidelines. ance with this subdivision must he nursing home.				
	by: Based on interview facility failed to ens testing for 4 of 5 re	ent is not met as evidenced and document review, the sure completion of tuberculosis sidents (R78, R96, R161, mployees (E5, E6, E8, E9).		Corrected		

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00144	B. WING		09/	02/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	ITER	ST 28TH STRI OUIS PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From pa	age 25	21426			
	Findings include:					
	skin test (TST) was was no read. A sec 3/17/11 and read o	e facility on 3/5/11. A tuberculir s administered on 3/8/11 but cond TST was administered on n 3/20/1. There was no otom screen prior to FST.				
	was administered of There was no evide	e facility on 6/28/16. A TST on 6/28/16 and read on 7/1/16. ence a second step TST was vas a symptom screed prior to ne first TST.				
	symptom screen w TST was administe	he facility on 5/25/16. A vas completed on 5/26/16. A ered on 5/26/16 and read on s no evidence of a second TST				
	was no evidence o	he facility on 7/21/16. There f a first or second step TST was there evidence of a				
	director of nursing resources departm monitoring of the e each employee sho screen completed further stated nursi resident TST's and	v on 9/2/16, at 7:27 a.m. the (DON) stated the human tent was responsible for imployee TST's. She stated ould have had a symptom and a two step TST. The DON ing was responsible for the I each resident should have reen and a two step TST.				
	director of nursing	THOD OF CORRECTION: The and/or infection control nurse plicies. The infection control)			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00144	B. WING		09/02/201	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
TEXAS 1	ERRACE CARE CEN	IFR	ST 28TH STRI DUIS PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
21426	Continued From pa	ge 26	21426			
	screened according Audits could be cor	all staff are appropriately to standards of practice. Inducted and the results ty committee for review.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21540	MN Rule 4658.131 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			10/12/10
	monitor each reside unnecessary drug u home's policies and pharmacist must re resident's attending physician does not home's recommend adequate justification believes the residen adversely affected, matter to the medical director is not the medical director is not the order and if the change the order, the review to the Qualite (QAA) committee re the attending physician	g. A nursing home must ent's drug regimen for usage, based on the nursing d procedures, and the port any irregularity to the physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nt's quality of life is being the pharmacist must refer the eal director for review if the not the attending physician. If r determines that the attending have adequate justification for attending physician does not he matter must be referred for y Assurance and Assessment equired by part 4658.0070. If ician is the medical director, macist shall refer the matter				
	by: Based on observati	ent is not met as evidenced on, interview and document ailed to monitor target		corrected		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00144	B. WING		09/	02/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	ITER	ST 28TH STRI OUIS PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21540	Continued From pa	age 27	21540			
	behaviors and efficacy, as well as orthostatic blood pressures when psychotropic medication was used for 1 of 5 residents (R37) reviewed for unnecessary medications.					
	Findings include:					
	nursing station talk was appropriate an R37 returned to be	on 8/31/16, at 8:46 a.m. at the ing on the phone. The residen nd calm. After the conversation er room and shut the door. 11:00 a.m. was lying in bed.	t			
	symptoms assess the resident had a psychotropic drug of R37 used Trazodor Seroquel for traum decline. The care p hypotension (sudder rising, common wit	R37's mood and behavior ment dated 11/10/15, indicated potential for side effects from use. The care plan identified ne for depression and latic brain injury with cognitive plan directed staff to monitor for en drop in blood pressure with th psychotropic medication d cognitive impairment	r			
	(CAA) for R37 date resident used Sero addition, the CAA in adverse effects fro	g use Care Area Assessment ed 11/19/15, indicated the oquel and Trazodone. In ndicated R37 had potential for m medications and directed to an for interventions.				
	orders for the antip (for Seroquel) 25 n behavioral disturba	ders dated 6/6/16, revealed osychotic, quetiapine fumarate ng twice daily for dementia with ances and the antidepressant promote sleep,Trazodone 150 depression.				
	B37's diagnoses in	ncluded dementia, traumatic				

			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		00144	B. WING		09/	02/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
τεγλς τ	ERRACE CARE CEN	7900 WE	ST 28TH STRE	ET		
		SAINT L	OUIS PARK, M	N 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21540	Continued From pa	ge 28	21540			
	brain injury and seizure disorder obtained from the quarterly MDS dated 8/6/16. In addition the MDS indicated R37 did not any behaviors and had severely impaired cognition.					
	the behavior of curs at others. At times re-approached an h pleasant. LPN-A fur support system and	3 p.m. LPN-A stated R37 had sing out but did not strike out she cursed at staff, but when nour or so later she would be rther stated R37 had a good d would use the phone to talk I not think R37 was depressed				
	never had any phys kicking or harming aware of. LPN-B in verbally aggressive	a.m. LPN-B stated R37 had sical behaviors of hitting, self or other that she was dicated the resident was very toward staff, depending if ed a rapport with her.				
	did not have a Serc use and R37 had n In addition, LPN-C pressures were obt further stating "The	a.m. LPN-C stated R37's chart oquel consent for medication o behavior monitoring in place stated no orthostatic blood ained in the last three months y are supposed to be done at for psychotropic medication				
	(LSW)-A acknowled not been completed LSW-A stated the s on only one occasio one had been track ensure behavior mo LSW-A further state	a.m. licensed social worker dged behavior monitoring had d for R37 for the last 90 days. staff had documented behavior on. LSW-A acknowledged no ing the documentation to ponitoring was being completed ed the social services st filled the positions which audit and review				

	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
	00144		B. WING	B. WING		02/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	IIEB	EST 28TH STRE OUIS PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21540	Continued From pa	age 29	21540			
	(NP) stated she we complete behavior had occasional psy with R37 that medi comfort and well be would have expect orthostatic blood p antipsychotic medi because of the pot hypotension with S On 9/1/16, at 4:24 stated she also wo	p.m. R37's nurse practitioner buld have expected the staff to tracking and trending as R37 ychosis. The NP had discussed cations were for the resident's eing. The NP further stated sho red the staff to monitor ressure for a resident on cation per facility protocol ential for orthostatic beroquel and Trazodone use. p.m. the director of nursing uld have expected the ponitored and orthostatic blood ecked monthly.	b			
	director of nursing records of resident medications for ap Education of appro Audits could be co brought to the qual TIME PERIOD FO	THOD OF CORRECTION: The or desginee could review is prescribed psychotropic propriate monitoring. opriate staff could be provided. nducted and the results lity committee for review. R CORRECTION: Twenty-one				
21670	(21) days. MN Rule 4658.140	5 A.B.C.D. Resident Units	21670			10/12/10
	The following items resident: A. A bed of pro convenience of the mattress, and clea weather and reside condition. Each be	s must be provided for each oper size and height for the e resident, a clean, comfortable n bedding, appropriate for the ent's comfort, that are in good ed must have a clean sture-proof mattress or	9			

If continuation sheet 30 of 49

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00144		B. WING		09/02/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN		ST 28TH STI OUIS PARK,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21670	confined to bed an Rollaway type beds not be used. B. A chair or p than the bed. C. A place adja personal possessio with a drawer. D. Clean bath often as needed. E. A bed light conv	st be provided for all residents d for other beds as necessary s, cots, or folding beds must lace for the resident to sit other acent or near the bed to store ons, such as a bedside table linens provided daily or more veniently located and of an ie needs of the resident while				
	by: Based on observat review the facility fa sanitary bed linens of 2 resident (R90) incontinence.	ent is not met as evidenced ion, interview and document ailed to ensure clean and were provided as needed for reviewed for urinary	1	corrected		
	interview and room observed not made with multiple smea was noted to have	39 a.m. during resident a observation the bed was a and the bottom fitted sheet rs of brown matter. The room a strong smell even though s running at the time.				
	observation the be both the fitted shee	I0 p.m. during a random room d was observed un-made and et and top sheet had smears of n addition the room had a				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A				(X3) DATE SURVEY COMPLETED		
		00144	B. WING		09/	02/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	IFR	ST 28TH STRI OUIS PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21670	On 8/30/16, at 7:09 in room watching te and asked about w resident stated he cares however staf keeping assisted h changing the beddi observed with mult On 8/31/16, at 12:1 (LPN)-A stated she assist any resident making sure soiled and getting gown a indicated there wer independent but sti some things. On 8/31/16, at 12:2 out of the room the of yellow brown sm assistant (NA)-C st change the linen fo for resident to be o and do it. He verifie and removed it from been to the room a thought on the last shift. On 9/1/16, at 9:41	age 31 9 a.m. resident was observed elevision. When approached hat assistance staff provided, was independent with all his if both nursing and house im with cleaning the room and ing's. The top sheet was iple smears of brown matter. 3 p.m. licensed practical nurse would expect the staff to who were independent with linen was changed on the bec mong other things. She re residents who were ill needed staff assistance with 29 p.m. resident was observed top sheet had multiple smear rears. At 12:30 p.m. nursing rated he was supposed to or resident however had to wait ut of his room for him to come ed resident sheet was soiled in the room. He stated he had ind changed the linen he two days before the end of the a.m. registered nurse (RN)-B I change them in the morning. lot of time in the room and is				
	cooperative for stat linen. Staff have to his ways." On 9/1/16, at 4:25	ff to approach and change the explain as resident is set in p.m. the director of nursing xpect the nursing assistant to				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00144	B. WING		09/02/	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	IFR	ST 28TH STRE DUIS PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETE DATE
21670	Continued From pa	ge 32	21670			
	mood disorder, type retinopathy obtaine	R90's diagnoses included asperger's syndrome, mood disorder, type II diabetes, constipation and retinopathy obtained from quarterly Minimum Data Set (MDS) dated 8/7/16.				
	R90's urinary incontinence and indwelling catheter Care Area Assessment (CAA) dated 11/11/15, indicated resident had occasional incontinence. Took care of himself and was able to make needs known. R90's alteration in bowel elimination care plan dated 1/15, indicated resident was continent of bowel and had history of constipation and diarrhea. Care plan directed staff to monitor the bowel elimination using care tracker.					
	On 9/2/16, at 8:00 a requested but was	a.m. the linen policy was not provided.				
	director of nursing of policies. Education provided. Room ob	THOD OF CORRECTION: The or desginee could review of appropriate staff could be servations/audits could be results brought to the quality w.				
	TIME PERIOD FOR (14) days.	R CORRECTION: Fourteen				
21980	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 3 Reporting - Inerable Adults	21980			10/12/16
	reporter who has re vulnerable adult is l or who has knowled has sustained a ph	of report. (a) A mandated eason to believe that a being or has been maltreated, dge that a vulnerable adult ysical injury which is not ed shall immediately report the				

MILLINESC	ota Department of He	aith				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00144	B. WING		09/02/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
		7900 WE	ST 28TH STR	EET		
IEXAS	FERRACE CARE CEN	SAINT LO	DUIS PARK, M	N 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21980	Continued From pa	ge 33	21980			
	information to the c individual is a vulne the individual is a dr reporter is not requi maltreatment of the to admission, unles (1) the individual wa another facility and believe the vulneral previous facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not provisions of this s as described above (c) Nothing in this known or suspected knows or has reaso been made to the c (d) Nothing in this reporter from also r agency. (e) A mandated r reason to believe th 626.5572, subdivisi (5), occurred must subdivision. If the r time believes that a agency will determin the reported error w the criteria under se 17, paragraph (c), of facility may provide directly to the lead a how the event meet 626.5572, subdivisi	ommon entry point. If an erable adult solely because nitted to a facility, a mandated ired to report suspected a individual that occurred prior s: as admitted to the facility from the reporter has reason to ble adult was maltreated in the nows or has reason to believe a vulnerable adult as defined 2, subdivision 21, clause (4). required to report under the ection may voluntarily report a. s section requires a report of d maltreatment, if the reporter on to know that a report has				

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00144	B. WING		09/0	2/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
TEXAS T	ERRACE CARE CEN	TER	T 28TH STF			
			UIS PARK, I		201	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 34	21980			
	information when m the report under su	naking an initial disposition of bolivision 9c.				
	by:	ent is not met as evidenced				
	facility failed to imm abuse to the design accordance with fac	and document review, the rediately report allegations of lated State agency (SA) in cility policy for 4 of 6 residents 0) who alleged mistreatment		corrected		
	Findings include:					
	6/24/16, indicated s required extensive a daily living. R29's ca her as a vulnerable abuse/neglect. The watch for signs and	inimum Data Set (MDS) dated he was cognitively intact and assistance with activities of are plan dated 6/16 identified adult and at risk for care plan directed staff to symptoms of abuse and gate concerns per policy.				
	roommate (R29) ha member approxima	0 a.m. R96 reported her Id been abused by a staff Itely one week prior, when a Itely wait for her medications				
	assistant (NA)-B trea and spoke to her in stated NA-B came a embarrassed her in room. R29 stated s following the incident taunting her. R29 st on her unit and she	p.m. R29 stated nursing eated her unprofessionally, "an abusive manner." She at her in a loud tone and front of everyone in the dining he cried for five hours nt and felt he was intentionally tated NA-B was still working preferred he not give her ere was no other option. She				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00144	B. WING		09/02/20	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	ITER	ST 28TH STRI OUIS PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21980	Continued From pa	age 35	21980			
	stated she had filed one of the staff.	d a complaint and gave it to				
	8/17/16, indicated regarding NA-B wh the concern form F "mentally abusive" enough problems w report indicated the request for pain me indicated after spe director (ED) felt he abuse/neglect." Th "trying to manipula is typical of her his					
	ED stated he was a abuse by R29. He the nurses on duty occurred. He furthe well and had receiv when asked what h had gotten "firm wi administrator state we were able to un abuse." During a s	d, because of R29's past, "I fel -substantiate the mental ubsequent interview at 1:58 d the incident should have				
	had moderately im also identified R75	DS dated 8/9/16, identified R75 paired cognition. The MDS required extensive assistance ssing, repositioning, toileting				
	vulnerable adult wi	ed 7/5/16, identified R75 as a th cognitive impairment, tion status as easily distracted,				

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00144	B. WING		09/02/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
TEXAS	FERRACE CARE CEN	TER	ST 28TH STRE DUIS PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AC REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO DEFICIEN DEFICIEN DEFICIEN		TION SHOULD BE	(X5) COMPLET DATE	
21980	and further indicate own concerns. The to report and invest A resident concern R75 had filed a con another NA who has stated staff had bee to his request to use reported that NA-F on 7/4/16 told R75 the did not want to co use the bathroom. signed by the ED or report" on the secon administrator had s about toileting, and tell a resident to go investigation further re-educated and ind held with the reside was "overall satisfied dated 7/21/16. Cor included a "Golden undated with the su residents to the bat in their briefs" which including NA-F. An interview with th revealed R75's con the SA. The ED sta concern immediate "un-substantiated" t concern to the SA. NA-F did not provid he had spoken with	d R75 was able to voice his care plan further directed staff igate all concerns per policy. report dated 7/5/16, indicated cern regarding NA-F and d worked on 7/4/16. R75 en taking 2-3 hours to respond e the bathroom. It was also and another aide who worked to "go in his briefs." R75 stated to that and wanted to instead The concern report had been n 7/5/16. The "Investigation nd page indicated the poken with NA-F on 7/6/16 NA-F stated she would never in their brief. The r indicated staff had been dicated a care conference was nt on 7/19/16 indicating R75 ed." The investigation was nponents of the investigation Rod" (education sheet) bject: "We always take hroom. Never ask them to go n had been signed by six NAs, e ED on 9/2/16, at 8:36 a.m. cern had not been reported to ted he had investigated the ly and found the concern to be herefore, did not report the The ED went on to say that e cares to other residents until her on 7/6/16, and since the bstantiated, NA-F had been				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00144	B. WING	B. WING		02/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	IFR	EST 28TH STR LOUIS PARK, M			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET DATE
21980	Continued From pa	age 37	21980			
	R19's Resident Co	ncern Report dated 8/8/16,				
		laughter wants to make a				
		r mom being treated rough by	/			
		nt 8.7.16. Aide who took care				
		when helping with changing				
		Daughter stated she had be had				
		have a female NA at all				
		stigative report indicated on				
		e call was made to the male N	A			
		ad been to the resident's roon				
	-	if he could change her and th	е			
		him to "come back at 0400"				
		n re-oriented resident to the				
		ked resident if he could chang hen allowed the cares. During				
		er asked him to stop or get a				
		er stated he was hurting her o				
	being or being roug					
		, R19 had been interviewed o ked if she felt she had	n			
		es over the last 24 hours "Yes,				
		ble with everyone who gave				
		d if she felt anyone had hurt				
	her over the last 24	hours and resident stated				
		ing the interview R19 reported	d			
		second floor and stated she				
	preferred a female	INA.				
	On 9/1/16 at 11.26	a.m. ED and DON were				
		viewed regarding the concern				
		ED stated the concerns was				
	not reported to the	SA, as the investigation was				
		the facility was made aware,				
		question had been able to				
		ne cares provided. ED stated				
		and unable to give specifics				
		l others had been interviewed cerns. ED further stated, "We				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00144	B. WING		09/02/2016	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
EXAS T	ERRACE CARE CEN	TER	ST 28TH STR			
		SAINT L	OUIS PARK, M		000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21980	Continued From pa	age 38	21980			
	should have report we took our 24 hou	ed it immediately instead, but irs to investigate."				
	had moderately im have any psychosis In addition, R19's of and anxiety. The or dated 6/16, identifie perception, was a v interviewable and r The care plan direct and investigate per R10's Resident Co filed by R158 on R reported to a staff s	dated 6/17/16, indicated R19 paired cognition and did not s, delusions, or hallucinations. diagnoses included dementia ognitive assessment care plan ed R19 had periods of altered vulnerable adult, was moderate impaired cognition. cted staff to report all concerns r policy. ncern Report dated 6/2/16, 10's behalf indicated R158 had seeing a staff person "push ulders in her room about a				
	had been interview reported "a week a [NA-E] pushed dow	dated 6/2/16, indicated R158 red at 4:15 p.m. and had go or so in the dining room vn on [R10's] shoulders when her chair and god dammit I n."				
	sheet indicated bot R158's accusation substantiated for a and family member witnessed NA-E or inappropriately. Th was at time agitate and staff did try to the chair unsafely b	d disposition of the concern th the ED and DON agreed was immediately not buse/neglect per staff, resident rs, and no one had ever any other staff treat R10 e report further indicated R10 d, was a fall risk and impulsive stop her from getting up out of but not in a malicious way and ring at any resident.	,			
	D10's admission M	IDS dated 5/19/16, indicated				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00144	B. WING	B. WING		09/02/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
TEVACT		7900 WE	ST 28TH STR	EET			
IEAAS I	ERRACE CARE CEN	SAINT L	OUIS PARK, M	N 55426			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21980	Continued From pa	age 39	21980				
		mpaired cognition with vandering behavior was					
	displayed extreme stealing his medica unreliable reporter. shift had been calle identified as very in falling. The ED indi nursing station, and when R10 stood, N okay. what do you bathroom?" When have been reported should have reported	a.m. the ED stated R10 behaviors, accusing staff of tions, causing a stir and was a The ED indicated staff on the ed in and interviewed. R10 was npulsive and at high risk for cated NA-E was behind d resident was behind the table IA-E rushed over and said "It's need? Do you need the asked if the allegation should d to the SA the ED stated "We ed it first and but we were able abuse in the first 24 hours."	6				
	Resident Mistreatm injuries of unknown of Resident Proper allegations that me substantiated violat agencies and to all local law enforcem Adult Protective Se takes all necessary on the result of the The center requires alleged violations to DON/designee imm as soon as possible after discovery of in shorter state time f	Prevention and Reporting: nent, Neglect, Abuse, Including a source, and Misappropriation ty policy directed "All et the definition of abuse and tions will be reported to state other agencies including the ent, elder abuse agencies, and rivices, as required. The center corrective actions depending investigation. s centers to report these of the executive director and nediately. 'Immediately' means e, but not to exceed 24 hours ncident, in the absence of a rame requirementNeglect: provide goods and services	d r				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/02/2016	
		00144				
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, S ⁻ E ST 28TH STRI			
TEXAS T	ERRACE CARE CEN	IFR	OUIS PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21980	Continued From pa	ige 40	21980			
	mental anguishM Includes, but is not harassment, and th deprivationProtect immediate safety of identification of pote mistreatment, injuri misappropriation of non-employee imm Suspend identified pending outcome of SUGGESTED MET administrator, direct social workers (LSV trained to immediat	ause physical harm, pain, or ental/Emotional abuse: limited to, humiliation, areats of punishment or otion 1. Provide for the f the resident upon ential abuse, neglect, es of unknown source, and/or property. Require identified ediately leave the center. employee (s) immediately f the investigation" THOD OF CORRECTION: Th tor of nursing and or licensed Ws) could ensure staff are tely report to the SA. e provided. Audits could be	e			
	committee for revie	results brought to the quality w. R CORRECTION: Fourteen				
22000		6.557 Subd. 14 (a)-(c) Itment of Vulnerable Adults	22000			10/12/16
	facility, except hom personal care atten establish and enfor prevention plan. Th assessment of the environment, and it factors which may e and a statement of to minimize the risk	s population identifying encourage or permit abuse, specific measures to be take of abuse. The plan shall es governing the plan				

(EACH DEFICIENCY REGULATORY OR L Continued From pa (b) Each facility, agency and person providers, shall dev prevention plan for residing there or re The plan shall cont assessment of: (1) abuse by other indi vulnerable adults; (other vulnerable ad specific measures t	TER 7900 WES SAINT LC ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 41 including a home health care al care attendant services velop an individual abuse each vulnerable adult ceiving services from them. ain an individualized) the person's susceptibility to viduals, including other 2) the person's risk of abusing dults; and (3) statements of the	A. BUILDING: B. WING DRESS, CITY, S DIS PARK, M PREFIX TAG 22000	TATE, ZIP CODE EET	
ERRACE CARE CEN SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa (b) Each facility, agency and person providers, shall dev prevention plan for residing there or re- The plan shall conta assessment of: (1) abuse by other indivi- vulnerable adults; (other vulnerable ad specific measures to	TER 7900 WES SAINT LC ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 41 including a home health care hal care attendant services velop an individual abuse each vulnerable adult ceiving services from them. ain an individualized) the person's susceptibility to viduals, including other 2) the person's risk of abusing dults; and (3) statements of the	DUIS PARK, M UIS PARK, M PREFIX TAG	EET IN 55426 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	(X5) 3E COMPLET
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa (b) Each facility, agency and person providers, shall dev prevention plan for residing there or re The plan shall cont assessment of: (1) abuse by other indi vulnerable adults; (other vulnerable ad specific measures t	TER 7900 WES SAINT LC ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 41 including a home health care al care attendant services velop an individual abuse each vulnerable adult ceiving services from them. ain an individualized) the person's susceptibility to viduals, including other 2) the person's risk of abusing dults; and (3) statements of the	DUIS PARK, M UIS PARK, M PREFIX TAG	EET IN 55426 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	E COMPLE
(EACH DEFICIENCY REGULATORY OR L Continued From pa (b) Each facility, agency and person providers, shall dev prevention plan for residing there or re The plan shall cont assessment of: (1) abuse by other indi vulnerable adults; (other vulnerable ad specific measures t	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 41 including a home health care hal care attendant services velop an individual abuse each vulnerable adult ceiving services from them. ain an individualized) the person's susceptibility to viduals, including other (2) the person's risk of abusing dults; and (3) statements of the	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	E COMPLE
(EACH DEFICIENCY REGULATORY OR L Continued From pa (b) Each facility, agency and person providers, shall dev prevention plan for residing there or re The plan shall cont assessment of: (1) abuse by other indi vulnerable adults; (other vulnerable ad specific measures t	A MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 41 including a home health care hal care attendant services velop an individual abuse each vulnerable adult ceiving services from them. ain an individualized) the person's susceptibility to viduals, including other (2) the person's risk of abusing dults; and (3) statements of the	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	E COMPLE
(b) Each facility, agency and person providers, shall dev prevention plan for residing there or re The plan shall cont assessment of: (1) abuse by other indi vulnerable adults; (other vulnerable ad specific measures t	including a home health care al care attendant services velop an individual abuse each vulnerable adult ceiving services from them. ain an individualized) the person's susceptibility to viduals, including other (2) the person's risk of abusing dults; and (3) statements of the	22000		
agency and person providers, shall dev prevention plan for residing there or re- The plan shall cont assessment of: (1) abuse by other indi vulnerable adults; (other vulnerable ad specific measures t	al care attendant services velop an individual abuse each vulnerable adult ceiving services from them. ain an individualized) the person's susceptibility to viduals, including other 2) the person's risk of abusing dults; and (3) statements of the			
adults. For the pur term "abuse" includ (c) If the facility, and personal care a knows that the vuln violent crime or an toward others, the i plan must detail the minimize the risk th reasonably be expe facility and persons unsupervised. Und	tt person and other vulnerable poses of this paragraph, the des self-abuse. except home health agencies attendant services providers, herable adult has committed a act of physical aggression individual abuse prevention e measures to be taken to hat the vulnerable adult might ected to pose to visitors to the s outside the facility, if der this section, a facility knows			
misconduct or phy- such information fro authority or through another facility, and	sical aggression if it receives om a law enforcement n a medical record prepared by other health care provider, or			
by:			corrected	
	and personal care knows that the vulr violent crime or an oward others, the blan must detail the ninimize the risk th easonably be expe acility and persons unsupervised. Unc of a vulnerable adult nisconduct or phy such information fr authority or through another facility, and he facility's ongoin vulnerable adult.	of a vulnerable adult's history of criminal nisconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or he facility's ongoing assessments of the vulnerable adult.	and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression oward others, the individual abuse prevention olan must detail the measures to be taken to minimize the risk that the vulnerable adult might easonably be expected to pose to visitors to the acility and persons outside the facility, if insupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or he facility's ongoing assessments of the rulnerable adult.	and personal care attendant services providers, snows that the vulnerable adult has committed a riolent crime or an act of physical aggression oward others, the individual abuse prevention olan must detail the measures to be taken to minimize the risk that the vulnerable adult might easonably be expected to pose to visitors to the acility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility's ongoing assessments of the rulnerable adult. This MN Requirement is not met as evidenced by: Corrected Based on interview and document review, the artment of Health corrected

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00144	B. WING		09/	09/02/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
TEXAS T	ERRACE CARE CEN	TER	ST 28TH STRI OUIS PARK, M				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
22000	Continued From pa	ige 42	22000				
	regarding investiga to the designated S residents (R29, R7 mistreatment by sta potential to affect a Findings include: The facility's 7/15, F Resident Mistreatm injuries of unknown of Resident Proper allegations that me substantiated violat agencies and to all local law enforceme Adult Protective Se takes all necessary on the result of the The center requires alleged violations to DON/designee imm as soon as possible after discovery of in shorter state time fin Neglect is failure to necessary to avoid anguish, or mental instances of abuse, those in a coma, ca mental anguishM Includes, but is not harassment, and th	s centers to report these o the executive director and nediately. 'Immediately' means e, but not to exceed 24 hours neident, in the absence of a rame requirementNeglect: o provide goods and services physical harm, mental illness. This presumes that /neglect of all residents, even ause physical harm, pain, or ental/Emotional abuse: limited to, humiliation, irreats of punishment or ction 1. Provide for the	ł r				
	mistreatment, injuri	ential abuse, neglect, es of unknown source, and/or property. Require identified					
		ediately leave the center.					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00144	B. WING		09/02/2016	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
EXAS T	ERRACE CARE CEN	TER	ST 28TH STRI			
		SAINT L	OUIS PARK, M	N 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
22000	Continued From pa	age 43	22000			
		employee (s) immediately of the investigation"				
	Findings include:					
	6/24/16, indicated s required extensive daily living. R29's o her as a vulnerable abuse/neglect. The watch for signs and neglect and investin On 8/29/16, at 10:1 roommate (R29) ha member approxima	linimum Data Set (MDS) dated she was cognitively intact and assistance with activities of are plan dated 6/16 identified a dult and at risk for care plan directed staff to d symptoms of abuse and gate concerns per policy. 10 a.m. R96 reported her ad been abused by a staff ately one week prior, when a e her wait for her medications				
	assistant (NA)-B tro and spoke to her in stated NA-B came embarrassed her in room. R29 stated s following the incide taunting her. R29 s on her unit and she medications, but th	p.m. R29 stated nursing eated her unprofessionally, n "an abusive manner." She at her in a loud tone and n front of everyone in the dining she cried for five hours ent and felt he was intentionally stated NA-B was still working preferred he not give her here was no other option. She d a complaint and gave it to				
	8/17/16, indicated I regarding NA-B wh the concern form F "mentally abusive" enough problems v	dent Concern Report dated R29 had filled out a report to "repeatedly" yelled at her. In R29 had indicated NA-B was to her and stated she had without him yelling at her. The e incident was regarding a				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00144	B. WING		09/02/2016	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
EXAS T	ERRACE CARE CEN	TER	ST 28TH STRE			
0(0)15			OUIS PARK, M	PROVIDER'S PLAN OF		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
22000	Continued From pa	age 44	22000			
	indicated after spe- director (ED) felt ha abuse/neglect." Th "trying to manipula is typical of her his During an interview ED stated he was abuse by R29. He the nurses on duty occurred. He further well and had receive when asked what h had gotten "firm wi administrator state we were able to un abuse." During a s	y on 8/13/16, at 11:29 a.m. the aware of the allegation of stated he was able to speak to the same day the incident er stated he knew NA-B very yed no concerns. He stated happened, NA-B had stated he th her [R29]." The d, because of R29's past, "I fel -substantiate the mental ubsequent interview at 1:58 d the incident should have				
	had moderately im also identified R75	OS dated 8/9/16, identified R75 paired cognition. The MDS required extensive assistance ssing, repositioning, toileting				
	vulnerable adult wi identified his cogni and further indicate own concerns. The	ed 7/5/16, identified R75 as a th cognitive impairment, tion status as easily distracted, ed R75 was able to voice his e care plan further directed staf tigate all concerns per policy.				
	R75 had filed a con another NA who ha stated staff had be to his request to us	report dated 7/5/16, indicated ncern regarding NA-F and ad worked on 7/4/16. R75 en taking 2-3 hours to respond se the bathroom. It was also and another aide who worked				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00144		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00144	B. WING		09/02/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	1	
		7900 WES	ST 28TH STR			
IEXAS	FERRACE CARE CEN	SAINT LC	UIS PARK, M	IN 55426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPL THE APPROPRIATE DAT	
22000	Continued From page 45 on 7/4/16 told R75 to "go in his briefs." R75 stated he did not want to do that and wanted to instead use the bathroom. The concern report had been signed by the ED on 7/5/16. The "Investigation report" on the second page indicated the administrator had spoken with NA-F on 7/6/16 about toileting, and NA-F stated she would never tell a resident to go in their brief. The investigation further indicated staff had been re-educated and indicated a care conference was held with the resident on 7/19/16 indicating R75 was "overall satisfied." The investigation was dated 7/21/16. Components of the investigation included a "Golden Rod" (education sheet) undated with the subject: "We always take residents to the bathroom. Never ask them to go in their briefs" which had been signed by six NAs, including NA-F.		22000			
	revealed R75's con the SA. The ED sta concern immediate "un-substantiated" concern to the SA. NA-F did not provic he had spoken with concern was not su allowed to continue R19's Resident Con indicated "[R19's] d complaint about he a male NA last nigh of [R19] was rough her under garment. concerns about mo wanted resident to times" The invest	cern had not been reported to ted he had investigated the ly and found the concern to be therefore, did not report the The ED went on to say that le cares to other residents until her on 7/6/16, and since the ubstantiated, NA-F had been				

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		00144			09/	09/02/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
TEXAS '	TERRACE CARE CEN	ITER	ST 28TH STRE OUIS PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	who indicated he h at 6:07 p.m. to ask resident had asked (4:00 a.m.). NA the time of day and asl the brief and R19 t the cares, R19 new female NA and new being or being roug In the investigation 8/8/16, and was as received good care if she felt comfortal her cares "Yes,"and her over the last 24 "No." However, dur a desire to move to preferred a female On 9/1/16, at 11:26 interviewed and rev report for R19. The not reported to the done the same day and that the NA in a describe in depth th R19 was confused and roommate and and offered no con should have report we took our 24 hou R19's annual MDS had moderately im have any psychosis In addition, R19's c and anxiety. The co dated 6/16, identified	ad been to the resident's room if he could change her and the d him to "come back at 0400" en re-oriented resident to the ked resident if he could change hen allowed the cares. During ver asked him to stop or get a ver stated he was hurting her o gh with pericare. , R19 had been interviewed on ked if she felt she had es over the last 24 hours "Yes," ble with everyone who gave d if she felt anyone had hurt 4 hours and resident stated ring the interview R19 reported o second floor and stated she NA. 6 a.m. ED and DON were viewed regarding the concern e ED stated the concerns was SA, as the investigation was y the facility was made aware, question had been able to he cares provided. ED stated and unable to give specifics d others had been interviewed cerns. ED further stated, "We ed it immediately instead, but	e r			

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		00144			09/	09/02/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
TEXAS T	ERRACE CARE CEN	ITER	ST 28TH STRI OUIS PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
22000	Continued From page 47		22000			
	interviewable and moderate impaired cognition. The care plan directed staff to report all concerns and investigate per policy.					
	R10's Resident Concern Report dated 6/2/16, filed by R158 on R10's behalf indicated R158 had reported to a staff seeing a staff person "push down on [R10] shoulders in her room about a week ago."					
	had been interview reported "a week a [NA-E] pushed dow	dated 6/2/16, indicated R158 red at 4:15 p.m. and had go or so in the dining room vn on [R10's] shoulders when her chair and god dammit I n."				
	sheet indicated bot R158's accusation substantiated for a and family member witnessed NA-E or inappropriately. Th was at time agitate and staff did try to the chair unsafely b	d disposition of the concern th the ED and DON agreed was immediately not buse/neglect per staff, residen rs, and no one had ever any other staff treat R10 e report further indicated R10 d, was a fall risk and impulsive stop her from getting up out of but not in a malicious way and ring at any resident.				
	R10 had severely i	IDS dated 5/19/16, indicated mpaired cognition with wandering behavior was				
	displayed extreme stealing his medica unreliable reporter. shift had been calle	a.m. the ED stated R10 behaviors, accusing staff of ations, causing a stir and was a The ED indicated staff on the ed in and interviewed. R10 was npulsive and at high risk for				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 09/02/2016	
		00144				
AME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
EXAS 1	FERRACE CARE CEN	IFR	ST 28TH STRE OUIS PARK, M			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page 48		22000			
	nursing station, and when R10 stood, N okay. what do you bathroom?" When have been reported should have report to un-substantiate SUGGESTED MET administrator, dired social workers (LS) trained to immedia Re-training could b conducted and the committee for revise	cated NA-E was behind d resident was behind the table IA-E rushed over and said "It's need? Do you need the asked if the allegation should d to the SA the ED stated "We ed it first and but we were able abuse in the first 24 hours." THOD OF CORRECTION: The totor of nursing and or licensed Ws) could ensure staff are tely report to the SA. e provided. Audits could be results brought to the quality ww. R CORRECTION: Fourteen				