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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XYMH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00144

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245187**

2. STATE VENDOR OR MEDICAID NO. (L2) **276542000**

3. NAME AND ADDRESS OF FACILITY
(L3) **TEXAS TERRACE CARE CENTER**
(L4) **7900 WEST 28TH STREET**
(L5) **SAINT LOUIS PARK, MN** (L6) **55426**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **07/01/2015**

6. DATE OF SURVEY **12/14/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **118** (L18)

13.Total Certified Beds **118** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	118			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Carrie Euerle, HFE NE II 1/24/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/27/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **02/01/1978** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **06301** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

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,

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

Minnesota Department of Health

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

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,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245187 Y1	A. Building B. Wing Y2	12/14/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TEXAS TERRACE CARE CENTER	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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 11/30/2016	ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 11/30/2016	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 11/30/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GD/kfd	DATE 1/24/2017	SIGNATURE OF SURVEYOR 31591	DATE 12/14/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/2/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

MDH
Minnesota Department of Health

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,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
00144		12/14/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TEXAS TERRACE CARE CENTER	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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20565 Reg. # MN Rule 4658.0405 Subp. 3 LSC	Correction Completed 11/30/2016	ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	Correction Completed 11/30/2016	ID Prefix 20900 Reg. # MN Rule 4658.0525 Subp. 3 LSC	Correction Completed 11/30/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GD/kfd	DATE 1/24/2017	SIGNATURE OF SURVEYOR 31591	DATE 12/14/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
9/2/2016	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XYMH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00144

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245187**

2. STATE VENDOR OR MEDICAID NO. (L2) **276542000**

3. NAME AND ADDRESS OF FACILITY
(L3) **TEXAS TERRACE CARE CENTER**
(L4) **7900 WEST 28TH STREET**
(L5) **SAINT LOUIS PARK, MN** (L6) **55426**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **07/01/2015**

6. DATE OF SURVEY **10/27/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **118** (L18)

13.Total Certified Beds **118** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	118			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Amy Charais, HFE NE II 12/6/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/15/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **02/01/1978** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **06301** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

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:

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)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the 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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245187	A. BUILDING _____ B. WING _____	R 10/27/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite resurvey was conducted by surveyors of this department on 10/25/16 through 10/27/16, to determine compliance with Federal deficiencies issued during a recertification survey exited on 9/2/16. During this visit the following regulations were determined to be not corrected. In addition, a new certification tag was written. Also there are tag/s that were not found corrected at the time of onsite PCR which are located on the CMS2567. The certification tags that were corrected can be found on the CMS2567B. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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	{F 000}		

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

Electronically Signed | 11/22/2016

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

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	245187	A. BUILDING _____ B. WING _____	R 10/27/2016

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{F 000}	Continued From page 1	{F 000}		

completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

On 9/2/16, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

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

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

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{F 282}	Continued From page 2	{F 282}		
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement care planned interventions for 1 of 3 residents (R148) reviewed who had sustained multiple falls in the facility. findings include: R148's significant change Minimum Data Set (MDS), dated 10/7/16, indicated he was severely cognitively impaired, incontinent of bowel and bladder, and required assistance with dressing, grooming, toileting, transfers and bed mobility. A Care Area Assessment (CAA) dated 10/7/16, indicated R148 was at risk for falls related to a history of falls, balance impairment and medication use and directed staff to refer to his care plan for interventions. R148's care plan dated 10/13/16, identified a history of falls in the facility and included the following interventions: Auto locking brakes to prevent the wheel chair from rolling backwards upon standing, grab bars, and orthostatic blood pressures weekly. A review of Texas Terrace Care Center Progress Notes dated 9/2/16 through 10/26/16 indicated R148 sustained more than twelve falls without injury in the facility since 9/2/16.	{F 282}	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 as 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 been 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 the implementation and use of fall interventions as ordered/recomended. 4. Director of Nursing/designee will audit 5 residents with falls per week for one month to assure fall interventions are care planned and in place. Continued audits of 5 residents per month will continue unitl	11/30/16

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{F 282}	Continued From page 3 During an observation on 10/27/16, at 8:06 a.m., R148 was self propelling on the unit. He was in a standard wheel chair with no auto locking brakes in place. An observation of R148's room identified grab were not place on his bed. A review of a Texas Terrace Medication Administration Record dated October 2016 indicated orthostatic blood pressures were to be completed weekly for R148 however, on both 10/3/16 and 10/10/16, the blood pressures were only completed while R148 was lying down and sitting up. No standing blood pressures were completed. On 10/17/16 and 10/24/16, there was no evidence of any blood pressures. During an interview on 10/26/16, at 11:40 a.m., licensed practical nurse (LPN)-C stated after a resident falls the nurse on the floor completed an incident report and the interdisciplinary team (IDT) reviews each fall. She stated during one of the IDT reviews it was determined that auto locking brakes would be implemented to prevent R148's chair from rolling backwards when he stood. LPN-C verified the auto-locking brakes had not been applied to R148's wheel chair. LPN-C further verified the orthostatic blood pressures had not been completed as directed in the care plan. During an interview on 10/26/16, at 1:49 p.m., the director of nursing (DON) stated R148 should have had grab bars placed on his bed. In regard to the orthostatic blood pressures, the DON stated they should have been changed to monthly instead of weekly, but stated they should have been completed if they were on the medication administration sheet.	{F 282}	dsicontinued by QAPI committee.	

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{F 282}	Continued From page 4 During an interview on 10/26/16, at 1:49 p.m., the registered nurse consultant stated R148 should have had auto locking brakes applied to his wheel chair. She stated the facility did not have them in stock and they had been ordered the previous day,15 days after the intervention was listed on the care plan. A facility policy titled Risk Reduction: Fall/Injury Assessment and Management Care Plan, dated July 2015 was reviewed. The policy directed staff to implement a fall/injury care pan based on the resident's needs and revise the care plan as needed to reduce the likelihood of another fall.	{F 282}		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess and identify pressure ulcers for 1 of 3 residents (R106), reviewed for nutritional risk but developed pressure ulcers in the facility. Findings include:	F 314	1. Resident #106 was evaluated by wound MD and area of deviation was diagnosed as moisture related dermatitis. Resident care plan has been reviewed and updated as indicated, including treatment of moisture barrier as ordered. NAR A and NAR B have recieved	11/30/16

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F 314	Continued From page 5 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. R106's Care Area Assessment (CAA) dated 1/22/16, indicated R106 was incontinent of bowel, assist of one for toileting, required an incontinent brief, required assist with bed mobility, at risk for skin breakdown and had a stage four pressure ulcer "resolved" 1/4/16. The CAA indicated the care plan should slow or minimize decline, avoid complications and minimize risks. On 10/25/16, at 2:38 p.m., R106 was observed sitting in his wheelchair in his room. On 10/26/16, at 10:51 a.m., R106 was observed sitting in his wheelchair in the dayroom drinking water out of a two handled lid cup. R106 stated he had been eating "pretty good." On 10/27/16, at 7:59 a.m., R106 was observed sitting in his wheelchair at a dining room table. R106 waved at surveyor and when approached, stated "my bottom hurts, can you tell [activities staff person]?." "[Activities staff person]" was identified as the activities (A) "go to" person on the floor. The conversation was reported at this time to A and licensed practical nurse (LPN)-C who stated R106 "does not have a pressure ulcer." On 10/27/16 at 8:44 a.m. R106 was observed to still be in dining room eating breakfast. When asked how breakfast was, R106 stated "I can't eat my bottom hurts so much" at which time R106 got tears in his eyes. This was again reported to	F 314	education related to notification of changes in resident status. 2. Resident skin sweep has been completed throughout the facility. Weekly skin checks are being completed by LN. 3. LN's and NAR's have been educated regarding skin policies, incluidng the identification of skin changes, reporting of skin changes and documentation of skin changes. 4. Director of Nursing/designee will audit 5 residents per week with high risk for skin alteration for one month to ensure skin protocols are in place including weekly skin assessment completed. Continued audits of 5 resident per month will be completed monthly until discontinued by QAPI.	

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F 314	Continued From page 6 LPN-C who stated "I repositioned him and the NA [nursing aide] this morning did not tell me there was anything wrong. I will check his bottom after breakfast." On 10/27/16, at 9:39 a.m. R106 was laying in bed and stated "I'm better now." R106 reached for grab bar but was unable to reposition himself. LPN-C used grab lift sheet to roll him to his side. A Stage II pressure ulcer (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater) on the coccyx was observed to be approximately 2.0 X .5 centimeter (cm) with non-blanchable surrounding tissue. Barrier cream was on the coccyx area. LPN-C stated "yes, that's greasy." At 9:42 a.m. LPN-C stated she was not aware of the pressure ulcer, "no one has told me." R106's care plan dated 10/14/16, indicated the weekly skin assessment was reviewed, Braden Risk Assessment (level of risk for development of pressure ulcers) of 17 on 8/8/16 indicating a mild risk of developing pressure ulcer, no skin/wound issues since last review and was one assist for transfers. The care plan directed staff to use lift sheet to move resident, increase frequency of turning if area of redness is non-blanchable, avoid positioning on trochanter (thigh bone), pressure reduction or pressure relief surface for chair and bed and apply topical skin protectant. Review of two EHSI Skin Assessments, both dated 10/14/16, indicated there were no "no areas of impairment." Review of a Braden Risk Assessment Scaled dated 10/14/16, indicated R106 had a score of 17, mild risk for pressure ulcer development.	F 314		

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F 314	Continued From page 7 Review of the nursing aide 2nd Floor Team 5 care sheet last updated 8/31/16, indicated R106 was assist of one for transfers and bed mobility and was to be turned and repositioned every two hours. Review of physician orders dated October 2016, indicated to conduct a weekly skin check on bath day (Friday PM) and apply dimethacone cream to buttocks twice daily (however this was discontinued on 9/26/16). Review of physician order dated 10/10/16, indicated to administer 120 milliliter house supplement twice a day. Review of the Treatment Order Sheets for September 2016, indicated two of five physician ordered weekly skin checks were not completed. Three of four physician ordered weekly skin checks for October 2016 were not completed. Allevyn dressing to coccyx, "change QOD [every other day] and prn (as needed), cleanse with NS [normal saline]" was added on 10/27/16. During interview on 10/27/16, at 10:31 a.m. nursing aide (NA)-A stated she saw the area was a little red yesterday but she did not tell the nurse and today she put barrier cream on the "sore" because the "bottom" looked different today than yesterday. NA-A stated she had washed him up and normally he doesn't complain until he sits in the chair, so "I laid him down in bed." NA-A stated R106 needed assist of two with the EZ stand and was "check and change" for toileting. During an interview on 10/27/16, at 11:44 a.m. R106 stated his bottom started to hurt "quite	F 314		

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F 314	Continued From page 8	F 314		

awhile ago", but was unable to state how long ago that was. R106's spouse (S)-A who shares the room stated he had an "abscess before, quite awhile ago." S-A stated she was "after" the aides to lay him down because he was sitting in his wheelchair from after lunch until the pm shift. S-A was unable to clarify when the incident happened.

During interview on 10/27/16, at 12:55 p.m. LPN-C stated R106 has had "on and off open areas on his coccyx and ischial tuberosity (IT)" but doesn't like to lay down", so that is when they got the tilt wheelchair so he could lay back. LPN-C stated R106 has had no wounds since 9/2/16, and has not had any for many months, although he had an abscess many months ago on his IT, "he could hardly sit." LPN-C stated she was not aware until now about the pressure ulcer and would have expected the aides to tell her, "even if it was just red."

During interview on 10/27/16, at 3:08 p.m. administrator stated another nursing aide, NA-B had cared for R106 on 10/25/16, and 10/26/16, pm shifts and night shift on 10/26/16, and NA-A cared for R106 on 10/26/16 and 10/27/16, am shifts. R106 was given a bath on 10/25/16, NA-B noticed some redness on the coccyx, but because it was closed and there was barrier cream in the room, he did use it and reapplied it every time R106 was repositioned. NA-B did not report this to anyone. NA-B stated on 10/26/16, night shift he noticed "some splitting", washed it with soap and water, did not use barrier cream and did not tell the night nurse, but stated he should have. Administrator verified any redness should have been reported and that there were four different opportunities for the aides to report the initial skin redness and then consequent open

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F 314	Continued From page 9 areas on the coccyx to nursing since 10/25/16. Review of the facility Wound Prevention and Treatment procedure dated July 2015 indicated the facility considers all residents as at risk for skin impairment and will implement the following interventions to prevent the development of pressure ulcers: "reduce occurrence of pressure over bony prominence to minimize injury, protect against the adverse effects of external mechanical forces (pressure, friction, shear) and increase the awareness of pressure ulcer prevention through educational programs." The Weekly Skin Assessment procedure dated July 2015, indicated the facility requires staff to complete a weekly skin assessment which includes a head to toe visualization of the residents skin, documenting any impairment, including the location, type and size, and the need to monitor until healed. A wound assessment completed by LPN-C on 10/27/16, was requested but not provided.	F 314		
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	{F 323}	1. Resident #148 fall care plan was	11/30/16

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{F 323}	Continued From page 10 review, the facility failed to implement interventions for 1 of 3 residents (R148) reviewed for accidents who sustained multiple falls in the facility. findings include: R148's significant change Minimum Data Set (MDS), dated 10/7/16, indicated he was severely cognitively impaired, incontinent of bowel and bladder, and required assistance with dressing, grooming, toileting, transfers and bed mobility. A Care Area Assessment (CAA) dated 10/7/16, indicated R148 was at risk for falls related to a history of falls, balance impairment and medication use and directed staff to refer to his care plan for interventions. A review of Texas Terrace Care Center Progress Notes dated 9/2/16 through 10/26/16, indicated R148 sustained more than twelve falls without injury in the facility since 9/2/16. A facility document titled Texas Terrace Occurrence dated 9/2/16, indicated R148 sustained a fall attempting to get to the bathroom. A Texas Terrace Occurrence dated 9/5/16, indicated R148 fell attempting to self transfer into his wheel chair. A Texas Terrace Occurrence dated 9/14/16, indicated he fell attempting to transfer from his wheel chair to his bed. A Texas Terrace Occurrence dated 9/27/16, indicated another fall reported by the resident but unwitnessed by staff. A Texas Terrace Occurrence dated 9/28/16, indicated resident was found lying next to his bed. On 9/30/16, an untitled document dated 9/30/16, indicated R148 fell again while attempting to self transfer. A Texas Terrace Occurrence dated 10/1/16,	{F 323}	reviewed and fall interventions have been implemented as care planned. 2. Residents 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 the implmentation and use of fall interventions as ordered/recommended. 4. Director of Nursing/designee will audit 5 residents with falls per week for one month to assure fall interventions are care planned and in place. Continued audit of 5 residents per month will continue until discontinued by QAPI.	

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{F 323}	Continued From page 11	{F 323}		

indicated he fell again transferring from his wheel chair to his bed. A Texas Terrace Occurrence dated 10/9/16, indicated he self reported a fall in his bathroom 2 days prior. A Texas Terrace Occurrence dated 10/10/16, indicated R148 fell while attempting to self transfer to the bathroom. On 10/17/16, a Texas Terrace Occurrence indicated he was found on the floor in his room by a housekeeper. Another Texas Terrace Occurrence dated 10/17/16 indicated he fell again attempting to transfer to the toilet. On 10/20/16, a Texas Terrace Occurrence indicated he was found on the floor beside his bed.

A review of R148's care plan dated 10/13/16, identified a history of falls in the facility and included the following interventions: Auto locking brakes to prevent the wheel chair from rolling backwards upon standing, grab bars, and orthostatic blood pressures weekly.

During an observation on 10/27/16, at 8:06 a.m., R148 was self propelling on the unit. He was in a standard wheel chair with no auto locking brakes in place. An observation of R148;s room identified no grab bars were in place on his bed.

A review of a Texas Terrace Medication Administration Record dated October 2016 indicated orthostatic blood pressures were to be completed weekly for R148 however, on both 10/3/16 and 10/10/16, the blood pressures were only completed while R148 was lying down and sitting up. No standing blood pressures were completed. On 10/17/16 and 10/24/16, there was no evidence of any blood pressures.

During an interview on 10/26/16, at 11:40 a.m., licensed practical nurse (LPN)-C stated after a

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 12	{F 323}		

resident falls the nurse on the floor completed an incident report and the interdisciplinary team (IDT) reviews each fall. She stated during one of the IDT reviews it was determined that auto locking brakes would be implemented to prevent R148's chair from rolling backwards when he stood. LPN-C verified the auto-locking brakes had not been applied to R148's wheel chair. LPN-C further verified the orthostatic blood pressures had not been completed as directed in the care plan.

During an interview on 10/26/16, at 1:49 p.m., the director of nursing (DON) stated R148 should have had grab bars placed on his bed. In regard to the orthostatic blood pressures, the DON stated they should have been changed to monthly instead of weekly, but stated they should have been completed if they were on the medication administration sheet.

During an interview on 10/26/16, at 1:49 p.m., the registered nurse consultant stated R148 should have had auto locking brakes applied to his wheel chair. She stated the facility did not have them in stock and they had been ordered the previous day,15 days after the intervention was listed on the care plan.

A facility policy titled Risk Reduction: Falls and Injuries Program, dated July 2015 was reviewed. The policy indicated the center strives to reduce the risk for falls and injuries by promoting the implementation of the falls and injuries program, provide an environment free form hazards and provide assistive devices to prevent avoidable accidents.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245187 Y1	A. Building B. Wing Y2	10/27/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TEXAS TERRACE CARE CENTER	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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0225	Correction	ID Prefix F0226	Correction	ID Prefix F0254	Correction
Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	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), 483.20(k)(1)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	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(l)	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 F0518	Correction	ID Prefix F0520	Correction	ID Prefix	Correction
Reg. # 483.75(m)(2)	Completed	Reg. # 483.75(o)(1)	Completed	Reg. #	Completed
LSC	10/16/2016	LSC	10/16/2016	LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	11/14/2016	35569	10/27/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
9/2/2016

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

MDH
Minnesota Department of Health

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,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245187 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	11/14/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TEXAS TERRACE CARE CENTER	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 Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	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		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	11/15/2016	37009	11/14/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
9/1/2016

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

MINNESOTA MDH DEPARTMENT OF HEALTH

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

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,

Kamala Fiske-Downing

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

Enclosure

cc: Licensing and Certification File
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00144	A. BUILDING: _____ B. WING _____	R 10/27/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS:	{2 000}		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 565	Continued From page 1 care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement care planned interventions for 1 of 3 residents (R148) reviewed who had sustained multiple falls in the facility. findings include: R148's significant change Minimum Data Set (MDS), dated 10/7/16, indicated he was severely cognitively impaired, incontinent of bowel and bladder, and required assistance with dressing, grooming, toileting, transfers and bed mobility. A Care Area Assessment (CAA) dated 10/7/16, indicated R148 was at risk for falls related to a history of falls, balance impairment and medication use and directed staff to refer to his care plan for interventions. R148's care plan dated 10/13/16, identified a history of falls in the facility and included the following interventions: Auto locking brakes to prevent the wheel chair from rolling backwards upon standing, grab bars, and orthostatic blood pressures weekly. A review of Texas Terrace Care Center Progress Notes dated 9/2/16 through 10/26/16 indicated R148 sustained more than twelve falls without injury in the facility since 9/2/16. During an observation on 10/27/16, at 8:06 a.m., R148 was self propelling on the unit. He was in a standard wheel chair with no auto locking brakes in place. An observation of R148's room identified	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 565	Continued From page 2 grab were not place on his bed. A review of a Texas Terrace Medication Administration Record dated October 2016 indicated orthostatic blood pressures were to be completed weekly for R148 however, on both 10/3/16 and 10/10/16, the blood pressures were only completed while R148 was lying down and sitting up. No standing blood pressures were completed. On 10/17/16 and 10/24/16, there was no evidence of any blood pressures. During an interview on 10/26/16, at 11:40 a.m., licensed practical nurse (LPN)-C stated after a resident falls the nurse on the floor completed an incident report and the interdisciplinary team (IDT) reviews each fall. She stated during one of the IDT reviews it was determined that auto locking brakes would be implemented to prevent R148's chair from rolling backwards when he stood. LPN-C verified the auto-locking brakes had not been applied to R148's wheel chair. LPN-C further verified the orthostatic blood pressures had not been completed as directed in the care plan. During an interview on 10/26/16, at 1:49 p.m., the director of nursing (DON) stated R148 should have had grab bars placed on his bed. In regard to the orthostatic blood pressures, the DON stated they should have been changed to monthly instead of weekly, but stated they should have been completed if they were on the medication administration sheet. During an interview on 10/26/16, at 1:49 p.m., the registered nurse consultant stated R148 should have had auto locking brakes applied to his wheel chair. She stated the facility did not have them in stock and they had been ordered the previous	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 565	Continued From page 3 day, 15 days after the intervention was listed on the care plan. A facility policy titled Risk Reduction: Fall/Injury Assessment and Management Care Plan, dated July 2015 was reviewed. The policy directed staff to implement a fall/injury care plan based on the resident's needs and revise the care plan as needed to reduce the likelihood of another fall. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by:	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 4 Based on observation, interview and document review, the facility failed to implement interventions for 1 of 3 residents (R148) reviewed for accidents who sustained multiple falls in the facility. findings include: R148's significant change Minimum Data Set (MDS), dated 10/7/16, indicated he was severely cognitively impaired, incontinent of bowel and bladder, and required assistance with dressing, grooming, toileting, transfers and bed mobility. A Care Area Assessment (CAA) dated 10/7/16, indicated R148 was at risk for falls related to a history of falls, balance impairment and medication use and directed staff to refer to his care plan for interventions. A review of Texas Terrace Care Center Progress Notes dated 9/2/16 through 10/26/16, indicated R148 sustained more than twelve falls without injury in the facility since 9/2/16. A facility document titled Texas Terrace Occurrence dated 9/2/16, indicated R148 sustained a fall attempting to get to the bathroom. A Texas Terrace Occurrence dated 9/5/16, indicated R148 fell attempting to self transfer into his wheel chair. A Texas Terrace Occurrence dated 9/14/16, indicated he fell attempting to transfer from his wheel chair to his bed. A Texas Terrace Occurrence dated 9/27/16, indicated another fall reported by the resident but unwitnessed by staff. A Texas Terrace Occurrence dated 9/28/16, indicated resident was found lying next to his bed. On 9/30/16, an untitled document dated 9/30/16, indicated R148 fell again while attempting to self transfer. A Texas Terrace Occurrence dated 10/1/16,	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 5 indicated he fell again transferring from his wheel chair to his bed. A Texas Terrace Occurrence dated 10/9/16, indicated he self reported a fall in his bathroom 2 days prior. A Texas Terrace Occurrence dated 10/10/16, indicated R148 fell while attempting to self transfer to the bathroom. On 10/17/16, a Texas Terrace Occurrence indicated he was found on the floor in his room by a housekeeper. Another Texas Terrace Occurrence dated 10/17/16 indicated he fell again attempting to transfer to the toilet. On 10/20/16, a Texas Terrace Occurrence indicated he was found on the floor beside his bed. A review of R148's care plan dated 10/13/16, identified a history of falls in the facility and included the following interventions: Auto locking brakes to prevent the wheel chair from rolling backwards upon standing, grab bars, and orthostatic blood pressures weekly. During an observation on 10/27/16, at 8:06 a.m., R148 was self propelling on the unit. He was in a standard wheel chair with no auto locking brakes in place. An observation of R148;s room identified no grab bars were in place on his bed. A review of a Texas Terrace Medication Administration Record dated October 2016 indicated orthostatic blood pressures were to be completed weekly for R148 however, on both 10/3/16 and 10/10/16, the blood pressures were only completed while R148 was lying down and sitting up. No standing blood pressures were completed. On 10/17/16 and 10/24/16, there was no evidence of any blood pressures. During an interview on 10/26/16, at 11:40 a.m., licensed practical nurse (LPN)-C stated after a resident falls the nurse on the floor completed an	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 6 incident report and the interdisciplinary team (IDT) reviews each fall. She stated during one of the IDT reviews it was determined that auto locking brakes would be implemented to prevent R148's chair from rolling backwards when he stood. LPN-C verified the auto-locking brakes had not been applied to R148's wheel chair. LPN-C further verified the orthostatic blood pressures had not been completed as directed in the care plan. During an interview on 10/26/16, at 1:49 p.m., the director of nursing (DON) stated R148 should have had grab bars placed on his bed. In regard to the orthostatic blood pressures, the DON stated they should have been changed to monthly instead of weekly, but stated they should have been completed if they were on the medication administration sheet. During an interview on 10/26/16, at 1:49 p.m., the registered nurse consultant stated R148 should have had auto locking brakes applied to his wheel chair. She stated the facility did not have them in stock and they had been ordered the previous day,15 days after the intervention was listed on the care plan. A facility policy titled Risk Reduction: Falls and Injuries Program, dated July 2015 was reviewed. The policy indicated the center strives to reduce the risk for falls and injuries by promoting the implementation of the falls and injuries program, provide an environment free form hazards and provide assistive devices to prevent avoidable accidents. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could educate staff to ensure each resident is assessed	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 7 for individual needs and supervision. The DON or designee could then perform audits to ensure each resident receives the care and supervision the individual requires. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess and identify pressure ulcers for 1 of 3 residents (R106), reviewed for nutritional risk but developed pressure ulcers in the facility. Findings include:	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00144	A. BUILDING: _____ B. WING _____	R 10/27/2016

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 8 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. R106's Care Area Assessment (CAA) dated 1/22/16, indicated R106 was incontinent of bowel, assist of one for toileting, required an incontinent brief, required assist with bed mobility, at risk for skin breakdown and had a stage four pressure ulcer "resolved" 1/4/16. The CAA indicated the care plan should slow or minimize decline, avoid complications and minimize risks. On 10/25/16, at 2:38 p.m., R106 was observed sitting in his wheelchair in his room. On 10/26/16, at 10:51 a.m., R106 was observed sitting in his wheelchair in the dayroom drinking water out of a two handled lid cup. R106 stated he had been eating "pretty good." On 10/27/16, at 7:59 a.m., R106 was observed sitting in his wheelchair at a dining room table. R106 waved at surveyor and when approached, stated "my bottom hurts, can you tell [activities staff person]?." "[Activities staff person]" was identified as the activities (A) "go to" person on the floor. The conversation was reported at this time to A and licensed practical nurse (LPN)-C who stated R106 "does not have a pressure ulcer." On 10/27/16 at 8:44 a.m. R106 was observed to still be in dining room eating breakfast. When asked how breakfast was, R106 stated "I can't eat my bottom hurts so much" at which time R106 got tears in his eyes. This was again reported to LPN-C who stated "I repositioned him and the NA [nursing aide] this morning did not tell me there	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00144	A. BUILDING: _____ B. WING _____	R 10/27/2016

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TEXAS TERRACE CARE CENTER	7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426

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2 900	Continued From page 9 was anything wrong. I will check his bottom after breakfast." On 10/27/16, at 9:39 a.m. R106 was laying in bed and stated "I'm better now." R106 reached for grab bar but was unable to reposition himself. LPN-C used grab lift sheet to roll him to his side. A Stage II pressure ulcer (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater) on the coccyx was observed to be approximately 2.0 X .5 centimeter (cm) with non-blanchable surrounding tissue. Barrier cream was on the coccyx area. LPN-C stated "yes, that's greasy." At 9:42 a.m. LPN-C stated she was not aware of the pressure ulcer, "no one has told me." R106's care plan dated 10/14/16, indicated the weekly skin assessment was reviewed, Braden Risk Assessment (level of risk for development of pressure ulcers) of 17 on 8/8/16 indicating a mild risk of developing pressure ulcer, no skin/wound issues since last review and was one assist for transfers. The care plan directed staff to use lift sheet to move resident, increase frequency of turning if area of redness is non-blanchable, avoid positioning on trochanter (thigh bone), pressure reduction or pressure relief surface for chair and bed and apply topical skin protectant. Review of two EHSI Skin Assessments, both dated 10/14/16, indicated there were no "no areas of impairment." Review of a Braden Risk Assessment Scaled dated 10/14/16, indicated R106 had a score of 17, mild risk for pressure ulcer development. Review of the nursing aide 2nd Floor Team 5 care sheet last updated 8/31/16, indicated R106 was	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 900	Continued From page 10 assist of one for transfers and bed mobility and was to be turned and repositioned every two hours. Review of physician orders dated October 2016, indicated to conduct a weekly skin check on bath day (Friday PM) and apply dimethacone cream to buttocks twice daily (however this was discontinued on 9/26/16). Review of physician order dated 10/10/16, indicated to administer 120 milliliter house supplement twice a day. Review of the Treatment Order Sheets for September 2016, indicated two of five physician ordered weekly skin checks were not completed. Three of four physician ordered weekly skin checks for October 2016 were not completed. Allevyn dressing to coccyx, "change QOD [every other day] and prn (as needed), cleanse with NS [normal saline]" was added on 10/27/16. During interview on 10/27/16, at 10:31 a.m. nursing aide (NA)-A stated she saw the area was a little red yesterday but she did not tell the nurse and today she put barrier cream on the "sore" because the "bottom" looked different today than yesterday. NA-A stated she had washed him up and normally he doesn't complain until he sits in the chair, so "I laid him down in bed." NA-A stated R106 needed assist of two with the EZ stand and was "check and change" for toileting. During an interview on 10/27/16, at 11:44 a.m. R106 stated his bottom started to hurt "quite awhile ago", but was unable to state how long ago that was. R106's spouse (S)-A who shares the room stated he had an "abscess before, quite awhile ago." S-A stated she was "after" the aides	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 900	Continued From page 11 to lay him down because he was sitting in his wheelchair from after lunch until the pm shift. S-A was unable to clarify when the incident happened. During interview on 10/27/16, at 12:55 p.m. LPN-C stated R106 has had "on and off open areas on his coccyx and ischial tuberosity (IT)" but doesn't like to lay down", so that is when they got the tilt wheelchair so he could lay back. LPN-C stated R106 has had no wounds since 9/2/16, and has not had any for many months, although he had an abscess many months ago on his IT, "he could hardly sit." LPN-C stated she was not aware until now about the pressure ulcer and would have expected the aides to tell her, "even if it was just red." During interview on 10/27/16, at 3:08 p.m. administrator stated another nursing aide, NA-B had cared for R106 on 10/25/16, and 10/26/16, pm shifts and night shift on 10/26/16, and NA-A cared for R106 on 10/26/16 and 10/27/16, am shifts. R106 was given a bath on 10/25/16, NA-B noticed some redness on the coccyx, but because it was closed and there was barrier cream in the room, he did use it and reapplied it every time R106 was repositioned. NA-B did not report this to anyone. NA-B stated on 10/26/16, night shift he noticed "some splitting", washed it with soap and water, did not use barrier cream and did not tell the night nurse, but stated he should have. Administrator verified any redness should have been reported and that there were four different opportunities for the aides to report the initial skin redness and then consequent open areas on the coccyx to nursing since 10/25/16. Review of the facility Wound Prevention and Treatment procedure dated July 2015 indicated the facility considers all residents as at risk for	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 900	Continued From page 12 skin impairment and will implement the following interventions to prevent the development of pressure ulcers: "reduce occurrence of pressure over bony prominence to minimize injury, protect against the adverse effects of external mechanical forces (pressure, friction, shear) and increase the awareness of pressure ulcer prevention through educational programs." The Weekly Skin Assessment procedure dated July 2015, indicated the facility requires staff to complete a weekly skin assessment which includes a head to toe visualization of the residents skin, documenting any impairment, including the location, type and size, and the need to monitor until healed. A wound assessment completed by LPN-C on 10/27/16, was requested but not provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing, and/or designee could assure policies and procedures are current, implemented, and monitored to assure nursing staff reassess, and adequently monitor for pressure ulcers. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 900		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00144 Y1	A. Building B. Wing Y2	10/27/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TEXAS TERRACE CARE CENTER	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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20255	Correction	ID Prefix 20300	Correction	ID Prefix 20560	Correction
Reg. # MN Rule 4658.0070	Completed	Reg. # MN Rule 4658.0105	Completed	Reg. # MN Rule 4658.0405 Subp. 2	Completed
LSC	10/16/2016	LSC	10/16/2016	LSC	10/16/2016
ID Prefix 20570	Correction	ID Prefix 20965	Correction	ID Prefix 21390	Correction
Reg. # MN Rule 4658.0405 Subp. 4	Completed	Reg. # MN Rule 4658.0600 Subp. 2	Completed	Reg. # MN Rule 4658.0800 Subp. 4 A-I	Completed
LSC	10/16/2016	LSC	10/16/2016	LSC	10/16/2016
ID Prefix 21426	Correction	ID Prefix 21540	Correction	ID Prefix 21670	Correction
Reg. # MN St. Statute 144A.04 Subd. 3	Completed	Reg. # MN Rule 4658.1315 Subp. 2	Completed	Reg. # MN Rule 4658.1405 A.B.C.D.	Completed
LSC	10/16/2016	LSC	10/16/2016	LSC	10/16/2016
ID Prefix 21980	Correction	ID Prefix 22000	Correction	ID Prefix	Correction
Reg. # MN St. Statute 626.557 Subd. 3	Completed	Reg. # MN St. Statute 626.557 Subd. 14 (a)-(c)	Completed	Reg. #	Completed
LSC	10/16/2016	LSC	10/16/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	11/14/2016	35569	10/27/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
9/2/2016

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XYMH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00144

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245187**

2. STATE VENDOR OR MEDICAID NO. (L2) **276542000**

3. NAME AND ADDRESS OF FACILITY
(L3) **TEXAS TERRACE CARE CENTER**
(L4) **7900 WEST 28TH STREET**
(L5) **SAINT LOUIS PARK, MN** (L6) **55426**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **07/01/2015**

6. DATE OF SURVEY **09/02/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **118** (L18)

13.Total Certified Beds **118** (L17)

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	118			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Amy Charais, HFE NE II 10/17/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/24/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **02/01/1978** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **06301** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

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:

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

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

Substandard Quality of Care - 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;

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

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

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

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

DEPARTMENT CONTACT

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

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 https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245187	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An investigation of complaint, H5187072 was completed. The complaint was not substantiated. An extended survey was conducted by the Minnesota Department of Health on 8/29/16 to 9/2/16.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	F 225		10/12/16

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

Electronically Signed | 09/30/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 1 misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of abuse to the designated State agency (SA) in accordance with facility policy for 4 of 6 residents (R29, R75, R19, R10) who alleged mistreatment by facility staff. Findings include: R29's admission Minimum Data Set (MDS) dated 6/24/16, indicated she was cognitively intact and required extensive assistance with activities of daily living. R29's care plan dated 6/16 identified her as a vulnerable adult and at risk for abuse/neglect. The care plan directed staff to watch for signs and symptoms of abuse and	F 225	Preparation, submission and implmentation 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 as 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 comliance. 1. Resident #10, #19, #29, and #75 greivances have been reviewed and reported to the state agency. 2. Resident allegations are being reported	

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F 225	Continued From page 2 neglect and investigate concerns per policy. On 8/29/16, at 10:10 a.m. R96 reported her roommate (R29) had been abused by a staff member approximately one week prior, when a staff member made her wait for her medications and laughed at her. On 8/30/16, at 6:31 p.m. R29 stated nursing assistant (NA)-B treated her unprofessionally, and spoke to her in "an abusive manner." She stated NA-B came at her in a loud tone and embarrassed her in front of everyone in the dining room. R29 stated she cried for five hours following the incident and felt he was intentionally taunting her. R29 stated NA-B was still working on her unit and she preferred he not give her medications, but there was no other option. She stated she had filed a complaint and gave it to one of the staff. A review of a Resident Concern Report dated 8/17/16, indicated R29 had filled out a report regarding NA-B who "repeatedly" yelled at her. In the concern form R29 had indicated NA-B was "mentally abusive" to her and stated she had enough problems without him yelling at her. The report indicated the incident was regarding a request for pain medications. The report further indicated after speaking with NA-B, the executive director (ED) felt he could "un-substantiate abuse/neglect." The report indicated R29 was "trying to manipulate pain meds [medications] as is typical of her history." During an interview on 8/13/16, at 11:29 a.m. the ED stated he was aware of the allegation of abuse by R29. He stated he was able to speak to the nurses on duty the same day the incident	F 225	to the Executive Director, Director of Nursing Services and reported to the state agency as required. 3. Staff will be re-educated regarding reporting and investigating allegations of mistreatment, neglect, abuse, injuries of unknown orgin, and misappropriation of resident property by 10/12/2016. 4. NHA/Designee will audit up to 2 allegations per week for implementation and investigation per policy for 1 month continued audits of 2 allegations will be completed monthly until discontinued by QAPI. Results of audit shared at QAPI.	

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F 225	Continued From page 3	F 225		

occurred. He further stated he knew NA-B very well and had received no concerns. He stated when asked what happened, NA-B had stated he had gotten "firm with her [R29]." The administrator stated, because of R29's past, "I felt we were able to un-substantiate the mental abuse." During a subsequent interview at 1:58 p.m. The ED stated the incident should have been reported to the SA.

R75's quarterly MDS dated 8/9/16, identified R75 had moderately impaired cognition. The MDS also identified R75 required extensive assistance of two staff for dressing, repositioning, toileting and bed mobility.

R75's careplan dated 7/5/16, identified R75 as a vulnerable adult with cognitive impairment, identified his cognition status as easily distracted, and further indicated R75 was able to voice his own concerns. The care plan further directed staff to report and investigate all concerns per policy.

A resident concern report dated 7/5/16, indicated R75 had filed a concern regarding NA-F and another NA who had worked on 7/4/16. R75 stated staff had been taking 2-3 hours to respond to his request to use the bathroom. It was also reported that NA-F and another aide who worked 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

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F 225	Continued From page 4	F 225		

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.

An interview with the ED on 9/2/16, at 8:36 a.m. revealed R75's concern had not been reported to the SA. The ED stated he had investigated the concern immediately and found the concern to be "un-substantiated" therefore, did not report the concern to the SA. The ED went on to say that NA-F did not provide cares to other residents until he had spoken with her on 7/6/16, and since the concern was not substantiated, NA-F had been allowed to continue working.

R19's Resident Concern Report dated 8/8/16, indicated "[R19's] daughter wants to make a complaint about her mom being treated rough by a male NA last night 8.7.16. Aide who took care of [R19] was rough when helping with changing her under garment. Daughter stated she had concerns about mom having a male NA and wanted resident to have a female NA at all times...." The investigative report indicated on 8/8/16, a telephone call was made to the male NA who indicated he had been to the resident's room at 6:07 p.m. to ask if he could change her and the resident had asked him to "come back at 0400" (4:00 a.m.). NA then re-oriented resident to the time of day and asked resident if he could change the brief and R19 then allowed the cares. During the cares, R19 never asked him to stop or get a female NA and never stated he was hurting her or being or being rough with pericare.

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F 225	Continued From page 5	F 225		

In the investigation, R19 had been interviewed on 8/8/16, and was asked if she felt she had received good cares over the last 24 hours "Yes," if she felt comfortable with everyone who gave her cares "Yes,"and if she felt anyone had hurt her over the last 24 hours and resident stated "No." However, during the interview R19 reported a desire to move to second floor and stated she preferred a female NA.

On 9/1/16, at 11:26 a.m. ED and DON were interviewed and reviewed regarding the concern report for R19. The ED stated the concerns was not reported to the SA, as the investigation was done the same day the facility was made aware, and that the NA in question had been able to describe in depth the cares provided. ED stated R19 was confused and unable to give specifics and roommate and others had been interviewed and offered no concerns. ED further stated, "We should have reported it immediately instead, but we took our 24 hours to investigate."

R19's annual MDS dated 6/17/16, indicated R19 had moderately impaired cognition and did not have any psychosis, delusions, or hallucinations. In addition, R19's diagnoses included dementia and anxiety. The cognitive assessment care plan dated 6/16, identified R19 had periods of altered perception, was a vulnerable adult, was 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

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F 225	Continued From page 6	F 225		

week ago."

In the investigation dated 6/2/16, indicated R158 had been interviewed at 4:15 p.m. and had reported "a week ago or so in the dining room [NA-E] pushed down on [R10's] shoulders when she stood up from her chair and god dammit I told you to sit down."

The Resolution and disposition of the concern sheet indicated both the ED and DON agreed R158's accusation was immediately not substantiated for abuse/neglect per staff, resident and family members, and no one had ever witnessed NA-E or any other staff treat R10 inappropriately. The report further indicated R10 was at time agitated, was a fall risk and impulsive and staff did try to stop her from getting up out of the chair unsafely but not in a malicious way and NA-E denied swearing at any resident.

R10's admission MDS dated 5/19/16, indicated R10 had severely impaired cognition with dementia, and no wandering behavior was displayed.

On 9/1/16, at 11:27 a.m. the ED stated R10 displayed extreme behaviors, accusing staff of stealing his medications, causing a stir and was a unreliable reporter. The ED indicated staff on the shift had been called in and interviewed. R10 was identified as very impulsive and at high risk for falling. The ED indicated NA-E was behind nursing station, and resident was behind the table when R10 stood, NA-E rushed over and said "It's okay. what do you need? Do you need the bathroom?" When asked if the allegation should have been reported to the SA the ED stated "We should have reported it first and but we were able

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F 225	Continued From page 7 to un-substantiate abuse in the first 24 hours." The facility's 7/15, Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including injuries of unknown source, and Misappropriation of Resident Property policy directed "All allegations that meet the definition of abuse and substantiated violations will be reported to state agencies and to all other agencies including the local law enforcement, elder abuse agencies, and Adult Protective Services, as required. The center takes all necessary corrective actions depending on the result of the investigation. The center requires centers to report these alleged violations to the executive director and DON/designee immediately. 'Immediately' means as soon as possible, but not to exceed 24 hours after discovery of incident, in the absence of a shorter state time frame requirement...Neglect: Neglect is failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. This presumes that instances of abuse/neglect of all residents, even those in a coma, cause physical harm, pain, or mental anguish...Mental/Emotional abuse: Includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation...Protection 1. Provide for the immediate safety of the resident upon identification of potential abuse, neglect, mistreatment, injuries of unknown source, and/or misappropriation of property. Require identified non-employee immediately leave the center. Suspend identified employee(s) immediately pending outcome of the investigation...."	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		10/12/16

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F 226	Continued From page 8 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to operationalize their facility policy regarding investigation and immediate reporting to the designated State agency (SA) for 4 of 6 residents (R29, R75, R19, R10) who alleged mistreatment by staff. These practices had the potential to affect all 101 residents in the facility. Findings include: The facility's 7/15, Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including injuries of unknown source, and Misappropriation of Resident Property policy directed "All allegations that meet the definition of abuse and substantiated violations will be reported to state agencies and to all other agencies including the local law enforcement, elder abuse agencies, and Adult Protective Services, as required. The center takes all necessary corrective actions depending on the result of the investigation. The center requires centers to report these alleged violations to the executive director and DON/designee immediately. 'Immediately' means as soon as possible, but not to exceed 24 hours after discovery of incident, in the absence of a shorter state time frame requirement...Neglect: Neglect is failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. This presumes that	F 226	1. Resident #10, #19, #29, and #75 greivances have been reviewed and reported to the state agency. 2. Potential allegations are being reported to the Executive Director and Director of Nursing Services and reported to the state agency as required. 3. Staff will be re-educated regarding reporting and investigating allegations of mistreatment, neglect, abuse, injuries of unknown orgin, and misapporpriation of resident property by 10/12/2016. 4. NHA/Designee will audit up to 2 allegations per week for implementation of policy and audit 3 staff members per week to assure policy understanding for one month. Continue audits of 2 allegations per month of allegation and 3 audits per month of staff understanding until discontinued by QAPI. Results will be shared at QAPI.	

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F 226	Continued From page 9 instances of abuse/neglect of all residents, even those in a coma, cause physical harm, pain, or mental anguish...Mental/Emotional abuse: Includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation...Protection 1. Provide for the immediate safety of the resident upon identification of potential abuse, neglect, mistreatment, injuries of unknown source, and/or misappropriation of property. Require identified non-employee immediately leave the center. Suspend identified employee(s) immediately pending outcome of the investigation...." R29's admission Minimum Data Set (MDS) dated 6/24/16, indicated she was cognitively intact and required extensive assistance with activities of daily living. R29's care plan dated 6/16 identified her as a vulnerable adult and at risk for abuse/neglect. The care plan directed staff to watch for signs and symptoms of abuse and neglect and investigate concerns per policy. On 8/29/16, at 10:10 a.m. R96 reported her roommate (R29) had been abused by a staff member approximately one week prior, when a staff member made her wait for her medications and laughed at her. On 8/30/16, at 6:31 p.m. R29 stated nursing assistant (NA)-B treated her unprofessionally, and spoke to her in "an abusive manner." She stated NA-B came at her in a loud tone and embarrassed her in front of everyone in the dining room. R29 stated she cried for five hours following the incident and felt he was intentionally taunting her. R29 stated NA-B was still working on her unit and she preferred he not give her medications, but there was no other option. She	F 226		

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F 226	Continued From page 10 stated she had filed a complaint and gave it to one of the staff. A review of a Resident Concern Report dated 8/17/16, indicated R29 had filled out a report regarding NA-B who "repeatedly" yelled at her. In the concern form R29 had indicated NA-B was "mentally abusive" to her and stated she had enough problems without him yelling at her. The report indicated the incident was regarding a request for pain medications. The report further indicated after speaking with NA-B, the executive director (ED) felt he could "un-substantiate abuse/neglect." The report indicated R29 was "trying to manipulate pain meds [medications] as is typical of her history." During an interview on 8/13/16, at 11:29 a.m. the ED stated he was aware of the allegation of abuse by R29. He stated he was able to speak to the nurses on duty the same day the incident occurred. He further stated he knew NA-B very well and had received no concerns. He stated when asked what happened, NA-B had stated he had gotten "firm with her [R29]." The administrator stated, because of R29's past, "I felt we were able to un-substantiate the mental abuse." During a subsequent interview at 1:58 p.m. The ED stated the incident should have been reported to the SA. R75's quarterly MDS dated 8/9/16, identified R75 had moderately impaired cognition. The MDS also identified R75 required extensive assistance	F 226		

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of two staff for dressing, repositioning, toileting and bed mobility.

R75's careplan dated 7/5/16, identified R75 as a vulnerable adult with cognitive impairment, identified his cognition status as easily distracted, and further indicated R75 was able to voice his own concerns. The care plan further directed staff to report and investigate all concerns per policy.

A resident concern report dated 7/5/16, indicated R75 had filed a concern regarding NA-F and another NA who had worked on 7/4/16. R75 stated staff had been taking 2-3 hours to respond to his request to use the bathroom. It was also reported that NA-F and another aide who worked 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.

An interview with the ED on 9/2/16, at 8:36 a.m. revealed R75's concern had not been reported to the SA. The ED stated he had investigated the concern immediately and found the concern to be

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"un-substantiated" therefore, did not report the concern to the SA. The ED went on to say that NA-F did not provide cares to other residents until he had spoken with her on 7/6/16, and since the concern was not substantiated, NA-F had been allowed to continue working.

R19's Resident Concern Report dated 8/8/16, indicated "[R19's] daughter wants to make a complaint about her mom being treated rough by a male NA last night 8.7.16. Aide who took care of [R19] was rough when helping with changing her under garment. Daughter stated she had concerns about mom having a male NA and wanted resident to have a female NA at all times...." The investigative report indicated on 8/8/16, a telephone call was made to the male NA who indicated he had been to the resident's room at 6:07 p.m. to ask if he could change her and the resident had asked him to "come back at 0400" (4:00 a.m.). NA then re-oriented resident to the time of day and asked resident if he could change the brief and R19 then allowed the cares. During the cares, R19 never asked him to stop or get a female NA and never stated he was hurting her or being or being rough with pericare.

In the investigation, R19 had been interviewed on 8/8/16, and was asked if she felt she had received good cares over the last 24 hours "Yes," if she felt comfortable with everyone who gave her cares "Yes,"and if she felt anyone had hurt her over the last 24 hours and resident stated "No." However, during the interview R19 reported a desire to move to second floor and stated she preferred a female NA.

On 9/1/16, at 11:26 a.m. ED and DON were

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interviewed and reviewed regarding the concern report for R19. The ED stated the concerns was not reported to the SA, as the investigation was done the same day the facility was made aware, and that the NA in question had been able to describe in depth the cares provided. ED stated R19 was confused and unable to give specifics and roommate and others had been interviewed and offered no concerns. ED further stated, "We should have reported it immediately instead, but we took our 24 hours to investigate."

R19's annual MDS dated 6/17/16, indicated R19 had moderately impaired cognition and did not have any psychosis, delusions, or hallucinations. In addition, R19's diagnoses included dementia and anxiety. The cognitive assessment care plan dated 6/16, identified R19 had periods of altered perception, was a vulnerable adult, was 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."

In the investigation dated 6/2/16, indicated R158 had been interviewed at 4:15 p.m. and had reported "a week ago or so in the dining room [NA-E] pushed down on [R10's] shoulders when she stood up from her chair and god dammit I told you to sit down."

The Resolution and disposition of the concern sheet indicated both the ED and DON agreed R158's accusation was immediately not

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F 226	Continued From page 14 substantiated for abuse/neglect per staff, resident and family members, and no one had ever witnessed NA-E or any other staff treat R10 inappropriately. The report further indicated R10 was at time agitated, was a fall risk and impulsive and staff did try to stop her from getting up out of the chair unsafely but not in a malicious way and NA-E denied swearing at any resident. R10's admission MDS dated 5/19/16, indicated R10 had severely impaired cognition with dementia, and no wandering behavior was displayed. On 9/1/16, at 11:27 a.m. the ED stated R10 displayed extreme behaviors, accusing staff of stealing his medications, causing a stir and was a unreliable reporter. The ED indicated staff on the shift had been called in and interviewed. R10 was identified as very impulsive and at high risk for falling. The ED indicated NA-E was behind nursing station, and resident was behind the table when R10 stood, NA-E rushed over and said "It's okay. what do you need? Do you need the bathroom?" When asked if the allegation should have been reported to the SA the ED stated "We should have reported it first and but we were able to un-substantiate abuse in the first 24 hours."	F 226		
F 254 SS=D	483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 254	1. Resident #90 has been provided with	10/12/16

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F 254	Continued From page 15 review the facility failed to ensure clean and sanitary bed linens were provided as needed for 1 of 2 resident (R90) reviewed for urinary incontinence. Findings include: R90's bed was unmade and the bottom fitted sheet with multiple brown smears on 8/29/16, at 10:39 a.m. The room had an odor, although there were two fans running at the time. On 8/30/16, at 7:09 a.m. R90 was in his room. When asked about what assistance staff provided, resident stated he was independent with all his cares, however, nursing and housekeeping staff assisted him with cleaning the room and changing bedding. The top sheet was observed with multiple brown smears. At 12:10 p.m. R90's bed was un-made and both the fitted sheet and top sheet had brown smears and odors were again detected. R90's urinary incontinence and indwelling catheter Care Area Assessment (CAA) dated 11/11/15, indicated the resident was able to make needs known. R90's bowel elimination care plan dated 1/15, indicated he was continent of bowel, but had a history of constipation and diarrhea. On 8/31/16, at 12:13 p.m. licensed practical nurse (LPN)-A stated she would have expected staff to assist any resident who was independent and ensure soiled linens were changed. She indicated there were residents who were independent but still needed staff oversight. On 8/31/16, at 12:29 p.m. R90 was not in his room. The top sheet was observed to have	F 254	clean bed linens and bed has been made. NA-C has been re-educated regarding changing of bed linen. 2. Residents will be provided with clean linen as needed and bed will be made on a daily basis as residents allow. 3. Nursing staff will be provided education regarding the provision of clean linen and bed making to residents by 10/12/2016. 4. DON/designee will audit 5 residents per week to assure linens are clean and bed is made for 1 month. Continued audits for 5 residents monthly until discontinued by QAPI. Results of audits shared at QAPI.	

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F 254	Continued From page 16 multiple yellow-brown smears. At 12:30 p.m. nursing assistant (NA)-C reported he was supposed to change the linen however, had to wait for R90 to be out of his room. He verified R90's sheet was soiled and removed it from the bed. NA-C stated he recalled changing the linen the previous two days toward the end of the shift. On 9/1/16, at 9:41 a.m. LPN-C explained staff, "should change them [linens] in the morning." LPN-C further stated R90 spent a lot of time in his room, but was cooperative with staff approaching to change the linen. "Staff have to explain as the resident is set in his ways." On 9/1/16, at 4:25 p.m. the director of nursing stated she would have expected NAs to assist resident to change their linens as needed. On 9/2/16, at 8:00 a.m. the linen policy was requested but was not provided.	F 254		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279		10/12/16

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F 279	Continued From page 17 psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a careplan for 1 of 2 residents (R95) who had been hospitalized for alcohol intoxication and had been known to use illegal substances in the facility. Findings include: R95's medical record progress notes included the following: A social service note dated 6/6/16, indicated, "SW [social worker] was informed that resident was found in a room rolling marijuana as cigs [cigarettes]. Smoking/Drugs policy was reviewed with resident." A social service note dated 6/7/16 read, "Resident was hosp. for BS due to ETOH[hospitalized for blood sugar due to alcohol] abuse. SW disposed of the remaining drink and a room search was done." A communication form and progress note dated 6/7/16 included R95 was sent to the hospital emergency room to evaluate and treat unresponsiveness and an elevated blood sugar reading. Written in above the R95's name included the following "[R95] was smoking pot	F 279	1.Resident #95 has a care plan that has been reviewed and updated. 2. Upon admission, quarterly, and with significant changes, resdients with history of ETOH, or illegal substance use have been reviewed and updated, including individualized interventions are in place. 3. The Unit Managers and Social Services staff will be provided with education regarding the care planning of substance abuse by 10/12/2016. 4. Director of Social Services/designee will audit 3 residents with substance use per week to assure care planning is complete and updated for substance use for 1 month. Continued audits of 3 residents will continue monthly until discontinued by QAPI. Results of the audit will be shared at QAPI.	

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F 279	Continued From page 18 last HS [night]." A nursing note dated 6/7/16 at 3:30 p.m. included R95 was incoherent and unresponsive with a blood sugar of 533. R95's nurse practitioner (NP) was called and provided an order for STAT [immediate] 10 units of Novalog insulin and to send to the emergency room for an evaluation. On 6/8/16, an interdisciplinary team note indicated the resident was hospitalized 6/7/16 for hyperglycemia and alcohol intoxication. R95 returned five hours later with no new orders. A social service note dated 6/25/16, read "Resident's care plan and assessments were reviewed with social worker, community police, guardian and resident. Review of the THC [drug] use over the weekend. Resident admitted to using and reported the source. Resident agreed not to repeat this behavior". A psychology referral was also set up by the licensed social worker (LSW). A nursing noted dated 6/26/16 at 3:00 p.m. R95 was "seen smoking with another resident [R118] an illegal substance. The nurse accompanied by a trained medication aide came out to the smoking are and smelled the substance. The residents were approached and asked if the substance was marijuana. The residents apologized to staff for smoking it but continued to pass it to one another. [R95] was searched and nothing found, she had no pockets and stated, 'there is no more.'" R95's NP and the director of nursing were notified. R95's careplan did not include the 6/7/16 hospitalization for alcohol use or the 6/6/16 and	F 279		

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F 279	Continued From page 19 6/25/16 use of marijuana. R95's cognitive testing 7/1/16, revealed the resident had moderate cognitive impairment. An interview on 9/1/16 at 9:14 a.m. with the executive director ED, DON and director of clinical services (DCS) confirmed that the care plan did not identify R95's alcohol or drug use in the facility, and that is should have been included on the careplan. A care plan policy was requested but was not provided.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		10/12/16

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F 280	Continued From page 20 This REQUIREMENT is not met as evidenced by: 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 2 residents (R118) identified to possess and use illegal substances. In addition, the facility failed to update and revise the careplan for weight loss and a change in dental status for 1 of 3 (R106) reviewed for weight loss. Findings include: R95 had a cognitive assessment dated 7/1/16, indicating moderate cognitive impairment. During entrance conference on 8/29/16, at 8:04 a.m. the facility identified R95 required supervision with smoking. A smoking assessment dated 3/31/16, identified R95 as independently able to smoke. R95's careplan dated 7/15, identified R95 smoked, however did not include if supervision was required. On 8/29/16, at 10:00 a.m. R95 was observed smoking on the Garden Terrace patio (approved supervised smoking area) during non-smoking hours. The surveyor asked registered nurse (RN)-A whether the resident was supposed to be smoking on the patio. RN-A replied "no" and assisted R95 back into the building. On 8/29/16, 3:15 p.m. R95 independently wheeled outside to the front of the facility, sat in front of the mailbox and smoked a cigarette, and then returned to the building.	F 280	1. Resident #95 and resident #177 have both been assessed per the smoking assessment/policy to be independent smokers and their care plans reflect this status. 2. Residents are assessed on admission, quarterly, and with significant change of status their ability to smoke. Care plans will be reviewed and updated accordingly with the assessment. 3. Staff and residents have been edcuated on facility smoking policy to ensure safety and secured storage of 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 assessments are accurate and complete, and materials are secured by the resident appropriately. Continued audits of 5 residents will continue monthly until discontinued by QAPI. Results of the audit will be shared at QAPI. 5) Resident #118 care plan has been reviewed and updated to indicate a history of marijuana use with measureable goals and individualized interventinos for resident safety. 6) Upon admission, quarterly and with significant changes residents with history of chemical dependency will be assessed. Their care plans for residents with history of illegal substance use have been reviewed to assure if suspicion of	

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F 280	Continued From page 21 On 8/30/16, at 7:24 p.m. R95 was observed sitting outside on the Garden Terrace patio smoking a cigarette. No staff was observed to be supervising the smoking. At 7:37 p.m. in the elevator R95's clothing and wheelchair were covered with cigarette ashes. There was a hole where the brake of the wheelchair attached that was also filled with ash. Review of R95's medical record progress notes included the following: A social service note dated 8/1/16 identified "SW informed resident that there will be scheduled times for smokers to go to the patio to smoke supervised. Resident signed the smoking policy and agreed to the rules. Resident is also able to sign out to go independently to smoke if she signs out." A social service note dated 8/2/16 noted "The concern is that the resident is unable to remember or comply with staff requests. SW called guardian who agrees to allow resident to smoke 'only' during supervised scheduled times as posted on each unit. The resident and staff were informed of the restriction and change--help resident comply with change." A nursing note dated 8/6/16, at 10:30 p.m. indicated R95 was observed smoking during non-smoking hours. R95 smoked another cigarette that she received from another resident. An interview with licensed social worker (LSW)-A on 8/31/16, at 10:42 a.m. confirmed R95 was only able to smoke while supervised on the patio during smoking times and her smoking materials	F 280	substance use is identified; measureable goals and individualized interventions are in place. 7) The Unit Managers and Social Services staff will be provided with education regarding the care planning of substance use by 10/12/2016. 8) Director of Social Services/designee will audit 3 residents with substance use per week to assure care planning is complete and updated for substance use for 1 month. Continued audits of 3 resdients will continue monthly until discontinued by QAPI. Results of the audit will be shared at QAPI. 9)Resident #106 has been reviewed and care plans have been updated for his change of dental status, weight loss, adaptive equipment, and intervetions in place to ensure measurable goals are being met. 10) Care plans are reviewed and updated upon admission, quarterly and with significant changes. The care plans for residents with change of dental status, weight loss, and adaptive equipment have been reviewed and updated and interventions as appropriate are care planned. 11) Unit Managers and Registered Dietician have been educated on care plan revisions for changes in dental status, adaptive equipment, and weight loss by 10/12/2016. 12) DON/designee will audit 3 residents per week to ensure care plans are accurate regarding dental status, concerns related to weight loss, and	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 22 should have been locked in the smoking cart. 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. R177 was identified by facility staff on 8/29/16, at 8:07 a.m. as a resident who smoked. A smoking assessment dated 8/11/16, indicated R177 independently smoked. R177's careplan dated 8/15/16, identified the resident as alert and oriented and someone who smoked. Interventions included smoking materials were to be kept in the smoking cart, however, did not indicate whether R177 required supervision with smoking. R177 was interviewed on 8/30/16, at 2:45 p.m. and stated that he was able to smoke independently and kept his cigarettes in his room. R177 stated he signed out to smoke and left and returned as he desired. R177 stated he did not go to the patio to smoke because smoke times were limited. On 8/30/16, at 8:14 p.m. R177 was independently smoking on the sidewalk outside the facility. On 8/31/16, at 1:35 p.m. R177 was hear inquiring of RN-A and LSW-C, why he had "to go outside supervised all of the sudden--why now?" On 8/31/16, at 3:03 p.m. R177 was interviewed about smoking at the facility and stated "I can't go outside here. They took my cigarettes and I can't go outside."	F 280	interventions needed to ensure resident well being. DON/desgnee to audit 3 residents care plans week for one month then 3 per month until discontinued by QAPI. Results of the audit will be shared at QAPI.	

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F 280	Continued From page 23 On 9/1/16, at 10:35 a.m. LSW-C was interviewed regarding R177 smoking unsupervised. LSW-C stated that smoking materials were kept locked up and whomever passed out the materials was responsible to know who required supervision for smoking and who was allowed to smoke independently. When asked if she was aware R177 had been keeping his own cigarettes she replied "I don't doubt that he keeps his cigarettes 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 on 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 iin 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 rractitioner] 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	F 280		

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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 independent with eating, and had no weight loss issues.

R106's Nutrition Risk Assessment dated 7/27/16, indicated R106 weighed 159 pounds 30 days prior 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)
- 7/16, no weights available
- 6/21/16, 159 lbs. (11 lbs or a 7.4% loss)
- 5/16, no weights available
- 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 and he drank better out of the 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.

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F 280	Continued From page 25 On 8/31/16, at 8:00 a.m. R106 was served breakfast, had a two-handled cup with a straw, cereal in a bowl and a regular plate. No staff assistance was provided with eating. The dietary card indicated a divided plate with raised sides should have been provided for R106. On 8/31/16, at 8:30 a.m. dietary staff (DS)-A stated cards for each person with assistive devices were on the cart, but were not always accurate. R106's current care plan dated 7/21/16, did not have weight loss as a concern and did not identify R106's tooth extractions. The care plan did not include the adaptive equipment for eating, and noted R106 was independent with eating. During an interview with the consulting dietitian on 9/1/16, at 12:20 p.m. she stated the care plan would be updated by nursing for oral surgeries. The weight of 148 pounds had not been brought to her attention. On 9/2/16, at 8:45 a.m. the care planning policy was requested but was not provided.	F 280		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by:	F 282		10/12/16

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F 282	Continued From page 26 Based on interview and document review, the facility failed to ensure supervision for smoking materials was provided for 2 of 7 residents (R101, R16) reviewed for accidents and failed to monitor weights for 1 of 3 residents (R16) reviewed for nutrition. In addition, failed failed to follow the plan of care for effective monitoring of psychotropic medications, including target behavior and orthostatic blood pressures for 1 of 5 residents (R37) reviewed for unnecessary medication use. Findings include: Smoking R101's diagnoses included malignant neoplasm of brain, major depressive disorder, anxiety, quadriplegia, muscle wasting and atrophy obtained from the admission record dated 4/4/16. On 8/30/16, at 11:06 a.m., 3:07 p.m., 5:08 p.m. to 5:26 p.m. and at 7:03 p.m. R101 sat on the electric wheelchair with head tilted back at the side walk in front of the main entrance to the facility and was smoking with no staff supervising. On 8/31/16, at 8:38 p.m. when asked the facility smoking policy, ED and DON both acknowledged they had observed R101 smoking outside on 8/30/16, "we talked to her and are sending out a memo to all residents that they cannot assist other residents to smoke." When asked who was responsible for checking in smoking items both indicated the facility did not have anyone. R101's fall/injury assessment care plan dated 4/1/16, indicated resident was a dependent smoker. Goal "will be free from serious injury	F 282	1. Resident #101 and #16 have been assessed per the smoking assessment/policy. Care plans have been updated accordingly. 2. Residents are assessed on admission,quarterly, and with significant change of status their ability to smoke. Care plans have been reviewed and updated to reflect individual interventions related to smoking, security of smoking materials, and safety plans. 3. Staff and residents have been educated on facility smoking policy to ensure safety and secured storage of 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 assessments are accurate and complete, and materials are secured by the resident appropriately. Continued audits of 5 residents will continue monthly until discontinued by QAPI. Results of the audits will be shared at QAPI. 5. Resident #16 weight has been obtained and nutritional assessment has been completed. The residetns care plan is reflective of goals and interventions obtained by these tools. 6.Residents' weights are obtained and are reviewed monthly or more frequently according to their individual needs. Care Plans with residents with nutritional or weight loss risks have been reviewed and updated as appropriate. 6. Staff has been educated on weights	

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F 282	Continued From page 27 related to smoking with personal care assistant [PCA]..." Care plan directed smoking materials will be kept at nursing station, monitoring compliance to smoking policy and PCA was to assist with smoking. Care plan did not address who was responsible for assisting R101 with smoking when PCA was not at the facility. R101's Smoking Safety Data Collection and Assessment dated 4/1/16, indicated resident was a dependent smoker with PCA assisting. R101's MN Smoking policy dated 4/1/16, signed on behalf of resident by PCA directed "3. All residents who smoke may only smoke in a designated smoking area. 7. All residents who smoke and who are assessed to be "Dependent" smokers will have all their smoking materials (matches, lighters, other sources of ignition, cigarette, electronic cigarettes, cigars, pipes, tobacco and/or other inhaled tobacco substitutes) stored in a secure area at the nurses station..." On 9/2/16, at 8:35 a.m. registered nurse (RN)-C stated R101 was a supervised dependent smoker and had the PCA bring her outside for smoking. When asked who supervised resident when PCA was not at the facility RN-C stated resident was supposed to follow the smoking scheduled times allowed by the facility. RN-C further stated if resident was not able light their own cigarette they would be supervised and another resident was not supposed to assist with lighting it or holding it for them. R16's diagnoses included chronic obstructive pulmonary disease (COPD), peripheral vascular disease, diabetes type II, anxiety, depression, schizophrenia and respiratory failure obtained	F 282	being obtained, notification of weight loss, and potential care plan interventions specifically related to chagnes in weight. 7. Staff have been educated on weights being obtained, notificiation of weight loss, and potential care plan interventions specifically related to changees in weight. 8. Director of Nursing/Designee will audit 10 resident weights per week to ensure completion. Director of Nursing/Designee will audit 3 resident nutritional assessments/care plans per week to ensure accuracy and interventions in place. Audits will be completed weekly for 1 month. Then 5 per month until discontinued by QAPI. Audit results will be shared at QAPI. 9. Resident #37 has been given consent for Seroquel, her behaviors have been reviewed, and residents NP has been updated, her othostatic blood pressure has been obtained. 10. Upon admission, quarterly and with significant changes, residents with psychotropic medications will be reviewed and documented on their behavior care plan including obtaining consents for their psychotropic medication, and orthostatic blood pressure taken on a monthly basis. 11. Unit Managers, license nurses, and the social services department has been educated on documenting behaviors on the behavior care plan, on providing residents with consent sheets when utilizing psychotropic medications, and monitoring of orthostatic blood pressure by 10/12/2016. 12. Director of Social Services/designee	

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F 282	Continued From page 28 from the quarterly MDS dated 7/8/16. In addition the MDS indicated resident did not have behaviors and had severely impaired cognition. On 8/30/16, at 7:28 p.m. R16 was observed smoking in the facility lower level smoking area, resident was noted with a trach. When approached resident stated he had been accused of smoking in his room and smoking near oxygen. "I feel I'm being watched unfairly, no one else gets watched." On 8/31/16, at 6:26 a.m. resident was observed outside on the side walk seated on his wheelchair (W/C) smoking right in front of the building un-supervised. -At 6:45 a.m. surveyor approached DON who confirmed resident was a supervised smoker "I had a talk with him." When asked where resident had gotten smoking material from DON stated "probably from another resident." -At 6:55 a.m. LPN-C stated resident was a supervised smoker and had violated the facility smoking policy and the facility was currently working with social service for placement to a facility with in-door smoking room. -At 7:16 a.m. LPN-C approached stated when a resident was considered a supervised smoked it met on a leave of absence (LOA) they could go out to the street and smoke. She indicated the facility did not have a "per say" supervised smoking program and stated she would find out and get back to surveyor. R16's Smoking Safety Data Collection and Assessment dated 8/2/16, indicated resident had history of smoking in room and none designated areas. Assessment did not indicate resident was a dependent bro supervised smoker rather	F 282	to audit 5 residents per week to ensure target behaviors on behavior care plans are documented and consistent with goals of psychotropic medications. Director of Nursing/designee to audit 5 residents per week to ensure orthostatic blood pressure are completed weekly for 1 month. Then 5 per month until discontinued by QAPI. Audit results will be shared at QAPI.	

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indicated resident was non-compliant with the smoking policy.

R16's fall/injury care plan assessment dated 5/11/16, indicated resident smoked and resident had been smoking in the room for the second time on 5/11/16. Care plan directed "if he has any only 1 cigarette at a time." In addition the care plan directed staff smoking materials would be kept at the nursing station. The care plan did not indicate if resident was an independent or dependent smoker even though had been found to have smoking supplies with him and had smoked in the room.

Nutrition
R16's diagnoses included dysphagia, gastrostomy status, tracheostomy status, hypothyroidism, anemia and diabetes type II obtained from the quarterly MDS dated 7/8/16. In addition the MDS indicated resident received tube feeding, "No or unknown" for loss of five percent (%) or more in the last month or loss of 10% or more in last six months and no weight was recorded in the MDS.

On 8/30/16, at 7:28 p.m. R16's was observed smoke outside on the lower level designated smoking area. R16 was noted with a trach. R16 approached surveyor and stated he had resided at the facility since since this last winter. "I have a trach, speech therapist won't let me eat, I'm on a tube feeding. I eat and drink when i get a chance. They are supposed to get me in for a swallow study as last time I had aspiration pneumonia and was at the hospital."

During document review it was revealed:

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F 282	Continued From page 30 -R16 had no condition or chronic disease that may result in a life expectancy of less than 6 months -Was not on a planned weight loss program -Had a 18 pounds (lbs) weight loss between the closest weight to survey and most recent re-admission weight which was a 9.7% weight loss. -Vital Signs-Individual Resident Flowsheet revealed no weights had been obtained or documented on admit 11/18/16, through 4/1/16. -4/2/16, weight was 199.8 lbs -4/7/16, weight was 202.0 lbs -4/11/16, weight was 202.6 lbs -May 2016 no weights obtained -June 2016 no weights obtained -7/7/16, refused weight -8/30/16, weight was 185.6 lbs obtained after surveyor requested R16 to be weighted. R16's nutrition care plan dated 4/4/16, indicated resident had a nutritional risk related to cardiac disease, was at risk for dehydration secondary to diabetes type II. Care plan goal "weight will remain stable +/-3%." Care plan directed staff to provide diet as ordered, nothing by mouth (NPO), supplements was ordered and monitor weights as needed (PRN) per protocol. The nutrition progress note dated 4/8/16, indicated R16 was to be followed up monthly for tube feeding tolerance and weight stability. Nutrition note dated 4/14/16, indicated resident was not meeting the estimated nutrition and hydration secondary to resident discontinuing himself from the tube feeding pump during the day to smoke and resident had agreed to change the feedings to bolus to help ease compliance of tube feeding.	F 282		

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R16's nutrition CAA dated 4/18/16, indicated resident had dysphagia and was nothing by mouth and received tube feeding.

On 8/30/16, at 11:40 a.m. consultant registered dietician (CRD) acknowledged it had been a struggle getting residents weighed when surveyors brought to her attention the multiple missing weights in several residents medical records. CRD stated she was doing assessments without weights and had to document weights were not obtained or refused.
-At 11:42 a.m. CRD stated "part of the issue was we had to be switched from other facilities and I started at the facility here in April." CRD stated she had been sending e-mails about the weight issues weekly to co-operate, the executive director (ED) and director of nursing were included on about the issue. CRD stated "To be honest I need other departments to jump on board so we can get this issue resolved." CRD acknowledged the nutritional assessments and MDS's were not accurate with weights not being available.

On 9/1/16, at 2:33 p.m. CRD stated When asked if resident weight was supposed to be monitored monthly CRD stated "I would like to keep up with it." CRD acknowledged the hindrance to monitoring residents who received tube feeding (TF) was learning the new role and balancing between two facilities. CRD stated she probably had noticed the missing weights at the moment and went along to another chart and never got back to it and over time failed through the crack.
-When asked if R16 had sustained a weight loss CRD stated she would consider a weight loss and thought she should have been notified of the

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weight loss between 4/11/16, and 8/30/16, weights. CRD stated she would expect the nurse who wrote it to have updated her. CRD further stated R16 was at a high risk for malnutrition and would re-evaluate current interventions since she had identified the 9.7% weight loss.

On 9/1/16, at 4:10 p.m. the nurse practitioner (NP) stated she would have expected the CRD to monitor R16's weights close due to R16's high risk for nutrition. NP stated she had received a call from one of the nurses at the facility indicating R16's tube feeding brand had run out and she had to give an order for a different brand. NP stated prior to giving the recent tube feeding order she had requested R16 to be seen by CRD but was told CRD had not seen R16 yet. NP further stated she had received reports of resident not being seen by the CRD and because of resident diabetes and refusing tube feeding was at a high risk for nutrition.

Unnecessary medication
R37 diagnoses included dementia, traumatic 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.

R37's physician order dated 6/6/16, revealed the following orders:
-Quetiapine Fumarate (Seroquel-antipsychotic) 25 mg by mouth twice daily for dementia with behavioral disturbances
-Trazodone (anti-depressant) 150 mg by mouth at bedtime for depression.

R37's psychotropic drug use CAA dated 11/19/16,

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indicated resident used Seroquel and Trazodone. In addition the CAA indicated resident had potential for adverse effects from medications and directed to review the care plan for interventions.

R37's care plan for mood and behavior symptoms assessment dated 11/10/15, indicated resident had potential for side effects related to psychotropic drug use. The care plan identified R37 used Trazodone for depression and Seroquel for traumatic brain injury (TBI) with cognitive decline. The care plan directed staff to monitor for hypotension, orthostatic blood pressure and behavior and cognitive impairment deterioration.

On 8/31/16, at 12:23 p.m. LPN-A stated R37 had the behavior of cursing out but did not hit, kick, punch anybody. She indicated overall after resident had cursed out if staff approached her in an hour or so she would be pleasant. When asked about R37's mood LPN-A stated resident had a good support system and would use the phone to talk with family and did not think resident was depressed.

On 9/1/16, at 6:45 a.m. LPN-B stated R37 had never had any physical behaviors of hitting, kicking or harming self or other that she was aware in the facility. LPN-B indicated resident was very verbally abusive to staff and this depended on if she had rapport with someone.

On 9/1/16, at 9:31 a.m. LPN-C nurse manager verified resident chart did not have a Seroquel consent for medication use and R37 had no behavior monitoring in place. In addition, LPN-C verified no orthostatic blood pressures had not

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 34 been obtained in the last three months "they are supposed to be done at least once a month for psychotropic medication use." On 9/1/16, at 10:06 a.m. licensed social worker (LSW)-A acknowledged behavior monitoring had not been completed for R37 for the last 90 days. LSW-A stated the staff had documented behavior only at one occasion. LSW-A acknowledged there had not been anybody looking at the staff documentation to make sure the behavior monitoring was being done. LSW-A further stated the social services department had just filled the positions which would help to closely audit and review for documentation of behavior moving forward. On 9/1/16, at 4:09 p.m. R37's NP stated she would expect facility was completing behavior tracking and trending as resident had occasional psychosis and had discussed with the family the medication was better for resident comfort and well being. NP further stated she would have expected the facility to monitor orthostatic blood pressure for a resident on antipsychotropic meds as that was a facility protocol she thought and the potential for orthosis as a side effect of Seroquel and Trazodone. On 9/1/16, at 4:24 p.m. the DON stated she would have expected the behaviors to be monitored and orthostatic blood pressures to be checked monthly as that was supposed to be checked monthly. On 9/2/16, at 8:45 a.m. the care plan policy was requested but was never provided.	F 282		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		10/12/16

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F 309 SS=D	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. 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 medications: Hydromorphone (for	F 309	1. Resident #16 has been reassessed for pain and expresses that he does not want any changes made to his pain regimen. NP has been updated with results of assessment and frequency of pain medication use. Care plans have been reviewed and updated accordingly. 2. Residnets are assessed for pain upon admission, quarterly, and with significant changes. Residents receiving PRN pain medicaiton have been assessed for effectiveness of medication regimen. NP's/MD's have been updated on frequent PRN use and care plans updated accordingly. 3. Nurses have been re-edcuated on the use of pain medications, documentation of non-pharmacological interventions and MD/NP notificaiton of frequent or ineffective pain management by 10/12/2016. 4. DON/designee will audit 5 residents receiving PRN pain medication weekly for 1 month to ensure residents pain medication program is effective, non pharmacological interventions are being	

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F 309	Continued From page 36 Dilaudid--narcotic pain medication) 4 milligram (mg) 1 tablet by mouth/via gastrostomy tube (G-tube) every 12 hours as needed (PRN) for pain not relieved with Tylenol (for mild to moderate pain), Acetaminophen cherry 20.3 milliliter (ml) (650 mg) via feeding tube every four hours as needed. R16 had no regularly scheduled pain medications. On 8/30/16, at 12:03 p.m. R16 reported he had pain in both legs. R16 did not want to talk anymore at this time. On 9/1/16, at 10:48 a.m. R16 stated he had slept well and did not have any pain at the time. R16 stated he was able to verbalize pain and staff gave him strong pain medications that staff gave him most of the time. R16's pain management care plan dated 4/1/16, indicated the resident had a potential for alteration in comfort related to pain secondary to diabetes. The goal was "No complaints of pain when questioned." The care plan directed staff to administer pain medications as ordered, monitor and record effectiveness and side effects of medications as needed, assess for verbal and not verbal signs and symptoms of distress, provide heat/cold packs and discuss concerns regarding pain management and review medication regimen with provider among others. During review of the medication administration records (MARs) the following were revealed: - 6/16, R16 was noted to receive PRN Dilaudid 4 mg 13 times this month. However, there was no evidence of the efficacy of the medication or any non-pharmacological interventions tried. Document review identified Tylenol had not been	F 309	used, and the pain flow sheet is being utilized. Continued audits of 5 residents will continue monthly until discontinued by QAPI. Results of the audit will be shared at QAPI.	

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administered the month of 6/16.
-7/16, R16 was noted to receive PRN Dilaudid 29 times in July. However, there was no consistent documentation of the efficacy of the medication or non-pharmacological interventions attempted. Document review indicated Tylenol was not administered the month of 7/16.
-8/16, R16 was noted to receive PRN Dilaudid 18 times this month. However, there was no consistent documentation of the efficacy of the medication or non-pharmacological interventions attempted. Review of documents revealed Tylenol was not provided the month of 8/16.

During further review of the interdisciplinary team notes, from 6/1/16, through 9/1/16, revealed no consistent documentation on non-pharmacological interventions, efficacy of medication, and if the provider had been updated on the increased pain and frequent use of PRN narcotics.

On 9/1/16, at 2:01 p.m. licensed practical nurse (LPN)-C stated she would expect the nurse's to call the nurse practitioner (NP) or primary doctor so pain medications could be routinely provided since R16 was receiving the PRN Dilaudid more frequently. LPN-C also stated she would expect the nurses to document non-pharmacological interventions prior to the medication being used as well as the efficacy of medication each time it was given. LPN-C stated another pain assessment should have been completed as with the pain assessment dated 7/1/16, R16 denied pain. However, R16 had frequently reported pain and received PRN pain medications.

On 9/1/16, at 4:10 p.m. the NP stated the facility had not called her regarding the frequent use of

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F 309	Continued From page 38 pain medications and increased reports of pain. The NP thought the primary doctor (MD) had seen R16 recently on 8/29/16, however the increased pain had not been reported to the physician. The NP stated she would expect the nurses to document non-pharmacological interventions before the PRN pain medication use as well as the efficacy of the pain medication if used. Review of NP and MD notes revealed there was no documentation of a pain review. On 9/1/16, at 4:22 p.m. the director of nursing (DON) stated she would expect the nurses to document non-pharmacological interventions before PRN pain medication, document the effectiveness and to have notified the doctor or NP on increased use of pain PRN medication.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure supervision was provided to minimize the risk for injury related to alcohol(ETOH)/drug use for 2 of 2 residents (R95, R118), and to ensure supervision related to smoking was for 4 of 7 residents (R95, R177, R101, R16) reviewed for accidents.	F 323	1. Resident #95 and #118 have had their care plan reviewed, updated, and interventions have been added to ensure residents safety and highest practical well being. 2. Residents with a history of substance abuse will be reviewed for safety and	10/12/16

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F 323	Continued From page 39 Findings include: R95's medical record progress notes included the following: A social service note dated 6/6/16, indicated, "SW [social worker] was informed that resident was found in a room rolling marijuana as cigs [cigarettes]. Smoking/Drugs policy was reviewed with resident." A social service note dated 6/7/16 read, "Resident was hosp. for BS due to ETOH[hospitalized for blood sugar due to alcohol] abuse. SW disposed of the remaining drink and a room search was done." A communication form and progress note dated 6/7/16 included R95 was sent to the hospital emergency room to evaluate and treat unresponsiveness and an elevated blood sugar reading. Written in above the R95's name included the following "[R95] was smoking pot last HS [night]." A nursing note dated 6/7/16 at 3:30 p.m. included R95 was incoherent and unresponsive with a blood sugar of 533. R95's nurse practitioner (NP) was called and provided an order for STAT [immediate] 10 units of Novalog insulin and to send to the emergency room for an evaluation. On 6/8/16, an interdisciplinary team note indicated the resident was hospitalized 6/7/16, for hyperglycemia and alcohol intoxication. R95 returned five hours later with no new orders. A social service note dated 6/25/16, read	F 323	supervision upon admission, quarterly and with significant changes. Residents who have a history of substance abuse have been identified and care plan interventions have been added to ensure resident safety and highest practical well being. 3. Staff have been re-educated on facility ETOH/drug use plan and expectations for follow up if residents are suspected of using either substance by 10/12/2016. 4. DSS/designee will audit 3 residents care plans per week for one month to ensure interventions are in place to promote well being and safety of residents. NHA/designee will audit 5 staff members per week for one month to ensure understanding of policy/steps to take if ETOH/drug use is suspected by any residents. After one month audits will continue for 3 care plans per month and 5 interviews per month until discontinued by QAPI. Results of audits will be discussed at QAPI. 5. Resident #95, #177, and #16 have been assessed per smoking assessment/policy to be independent smokers. Resident #101 has been assessed per smoking assessment/policy to be a dependent smoker. 6. Residents who smoke will be reviewed upon admission, quarterly, and significant changes. Residents who currently smoke have been reviewed and individualized interventions have been put in place to promote resident well being as needed. 7. Staff has been edcuated on facility smoking policy, indivdualized interventions, and system in place to	

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F 323	Continued From page 40 "Resident's care plan and assessments were reviewed with social worker, community police, guardian and resident. Review of the THC [drug] use over the weekend. Resident admitted to using and reported the source. Resident agreed not to repeat this behavior". A psychology referral was also set up by the licensed social worker (LSW). A nursing noted dated 6/26/16 at 3:00 p.m. R95 was "seen smoking with another resident [R118] an illegal substance. The nurse accompanied by a trained medication aide came out to the smoking are and smelled the substance. The residents were approached and asked if the substance was marijuana. The residents apologized to staff for smoking it but continued to pass it to one another. [R95] was searched and nothing found, she had no pockets and stated, 'there is no more.'" R95's NP and the director of nursing were notified. A patient care visit note made by R95's physician dated 6/15/16, identified "substance abuse-recent ER visit with alcohol use and nursing staff have reported several occasions where she has been caught with marijuana." In the assessment/plan portion of the patient care visit note the physician indicated an "absolute need to avoid ETOH discussed with patient". R95's face sheet was reviewed and identified R95 was admitted to the facility on 11/25/15 with diagnoses including depressive disorder, anxiety, and Hepatitis C. An interview with LSW-A on 8/31/16, at 10:42 a.m. confirmed he was aware of R95's alcohol use in the facility and use of marijuana with	F 323	monitor smoking materials to ensrue they are stored securely by 10/12/2016. 8. Director of Social Services/Designee will audit 5 residents per week to ensure smoking assessments are accurate and up to date. NHA/designee will audit 5 staff members per week to ensure understanding of smoking policy and expectation of supervision of smoking materials. Audits will be performed weekly for 1 month, then 5 per month until discontinued by QAPI. Results of audit to be shared at QAPI.	

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another resident (R118). LSW-A could not recall how he became aware of the alcohol use or marijuana use but assumed it was from staff report or the 24-hour board.

An interview with licensed practical nurse (LPN)-C on 8/31/16 at 11:07 a.m. confirmed she was aware of R95's 6/7/16 hospitalization for alcohol intoxication, however the related hospital notes were not found in R95's medical record. LPN-C confirmed hospitalizatino information should have been included in the medical record. LPN-C was "not sure" how R95 had obtained alcohol. LPN-C stated she was also aware of R95's marijuana use with R118, and assumed R95 obtained the marijuana from the other resident. LPN-C went on to say staff should have documented use of alcohol or marijuana, called the DON executive director, and the police. LPN-C stated although staff was aware, alcohol and marijuana use were not included on R95's careplan. There was no direction for staff intervention if R95 was using those substances.

The hospital record from the 6/7/16, emergency room visit was requested and provided which indicated R95 was treated for elevated blood sugar levels, alcohol intoxication and altered mental status.

R118's admission face sheet was reviewed and indicated R118 admitted to the facility in 4/16 with diagnoses including hepatitis B.

A nursing note dated 6/26/16, at 2:30 p.m. indicated R118 was observed smoking an illiegal substance with with another resident (R95). The Garden terrace nurse accompanied by a trained medication aide went to the smoking area,

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smelled marijuana and approached the residents. When asked about the substance the residents stated it was marijuana. They apologized to staff for smoking, but continued to pass it to one another. R118 stated "We only smoked what I had. There is nothing else I promise." The nurse practitioner (NP) was updated.

R118's careplan dated 7/16, identified R118 "has been caught smoking marijuana--states it's for pain relief--knows it's illegal. NP aware--hold all narcotics if pot suspected/witnessed." The careplan did not identify any further interventions for staff if R118 was using or suspected of using illegal substances.

R118's pain data collection and assessment dated 7/11/16, indicated R118 had a history of pelvic fracture pain and listed under non-pharmacological approaches tried (and effectiveness): "smoking, repositioning, pot--knows its illegal".

A cognitive assessment dated 7/13/16, identified R118 had moderate impairment. An interdisciplinary team (IDT) note dated 7/27/16, indicated R118 reported she smoked marijiuana to relieve chronic pain. The NP was aware and narcotic pain medication was held when smoking marijiuana.

The ED, DON, and director of clinical services (DCS) were interviewed on 9/1/16, at 9:14 a.m. and stated they were aware of R118's marijuana use, but were unaware she was sharing it with R95. They confirmed staff should have doucmented incidents and they would have expected to be informed and the situation investigated. The ED and DON confirmed R118's

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careplan was "poorly written" and did not direct staff to call the police or complete a room search when substance use was suspected. The DON stated that staff was educated on a facility marijuana protocol, however a copy of the marijuana protocol was not provided. The ED provided a PowerPoint presentation with one slide entitled "Financial's/ETOH" that directed staff for alcohol use to do the following: "NARS [nursing assistants/registered] notify nurse, confront resident, smell breath/look for signs, call NP, conduct room search and confiscate alcohol, document in resident chart, document on 24 hour board!!! use the 24 hour board to all updates. NO NOTES! CALL DON! CALL ADMINISTRATOR! (sex, money, alcohol, etc.), EJA [Elder Justice Act] standards and reporting requirements."

A follow up interview with the director of clinical services (DCS) on 9/1/16, at 1:45 p.m. revealed the nurse documenting the progress note of 6/26/16, was not actually a witness to the event between R118 and R95. The DCS explained, "The nurse wasn't outside so she couldn't document what had happened. The NA was there but she didn't document it. We had her write a statement. We should've investigated and documented it...Obviously it's a systems issue" and they needed a system to thoroughly document it. When asked if the facility considered how the residents were obtaining drugs and if there was exposure to contagious diseases, the DCS replied "I didn't even think of that."

Smoking:
R95 had a cognition assessment dated 7/1/16, indicating moderate cognitive impairment. During entrance conference on 8/29/16, at 8:04 a.m. the facility identified R95 was a supervised smoker.

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F 323	Continued From page 44 A smoking assessment dated 3/31/16, identified R95 as an independent smoker. R95's careplan dated 7/15, identified R95 was a smoker, however did not include R95 required supervision with smoking. On 8/29/16, at 10:00 a.m. R95 was observed smoking on the Garden Terrace patio (approved supervised smoking area) during non-smoking hours. The surveyor asked registered nurse (RN)-A if R95 was supposed to be smoking on the patio and RN-A stated "no" and went out to assist R95 back into the building. On 8/29/16, 3:15 p.m. R95 was observed to wheel herself outside to the front of the facility, sat in front of the mailbox and smoked a cigarette. R95 then wheeled herself back into the facility backwards. On 8/30/16, at 7:24 p.m. R95 was observed sitting outside on the Garden Terrace patio smoking a cigarette. No staff was observed to be supervising the smoking. R95 requested assistance of the surveyor to get back into facility, she was unable to get back up the sidewalk from the smoking area. Staff was obtained to assist R95 back into the facility. A coffee can was observed on the patio to dispose of cigarettes. At 7:37 p.m. in the elevator R95's clothing and wheelchair were observed to be covered with cigarette ashes. There was a hole where the brake of the wheelchair attached that was also filled with ash. Review of R95's medical record progress notes included the following:	F 323		

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A social service note dated 8/1/16 identified "SW informed resident that there will be scheduled times for smokers to go to the patio to smoke supervised. Resident signed the smoking policy and agreed to the rules. Resident is also able to sign out to go independently to smoke if she signs out."

A social service note dated 8/2/16 noted "SW was informed that staff has witnessed resident outside the facility, signed out for smoking. The staff report that resident has been seen pushing herself backwards in her chair, unaware of the possibility of falling off the curb or sidewalk. The resident has been redirected twice not to do this. The concern is that the resident is unable to remember or comply with staff requests. SW called guardian who agrees to allow resident to smoke "only" during supervised scheduled times as posted on each unit. The resident and staff were informed of the restriction and change-help resident comply with change."

A nursing note dated 8/6/16, at 10:30 p.m. indicated R95 was observed smoking during non-smoking hours. R95 and other residents were informed and advised of the consequence of violating the new smoking policy. R95 and other residents became agitated and disrespectful. R95 smoked another cigarette that she received from another resident.

Interview with SW-A on 8/31/16, at 10:42 a.m. confirmed R95 was only able to smoke while supervised on the patio during smoking times and her smoking materials were to be locked in the smoking cart. SW-A could not confirm who was responsible to manage the smoking cart.

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Interview with licensed practical nurse (LPN)-C on 8/31/16, at 11:07 a.m. confirmed R95 was a smoker who required staff supervision and that all smoking materials would be kept in the smoking cart. LPN-C stated nursing assistants supervised smoking during the posted times.

R177's face sheet included an admission date to the facility of 8/9/16 and included diagnoses of chronic obstructive pulmonary disease (COPD), anxiety, and hypertension. Upon entrance conference with the facility on 8/29/16, at 8:07 a.m. R177 was identified as a smoker who required supervision with smoking.

A smoking assessment dated 8/11/16, indicated R177 was an independent smoker.

R177's careplan dated 8/15/16, identified R177 as alert and oriented and a smoker. The careplan included R177's smoking materials would be kept in the smoking cart but failed to identify R177 required supervision with smoking.

R177 was interviewed on 8/30/16, at 2:45 PM and stated that he was able to smoke by himself and kept his cigarettes in his room. R177 stated he was able to sign out to smoke, he left and came back when he wanted to. R177 stated he did not go to the patio to smoke because they limited times to smoke.

On 8/30/16, at 8:14 p.m. R177 was observed on the sidewalk outside of the facility independently smoking. It was dark outside and R177 was standing smoking on the sidewalk with four other residents (R39, R118, R51, R101) with no staff supervision. No receptacle was available to deposit cigarettes and the four additional

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residents were observed putting out their cigarettes on the sidewalk. R39 was observed "ashing" her cigarette into a Styrofoam coffee cup.

On 8/30/16, at 7:07 p.m. LPN-C stated if residents were assessed as safe to smoke on their own, unsupervised, they signed out at the front desk, got cigarettes from the smoking cart and could leave the facility. If people were smoking on the patio they should get cigarettes from the smoking cart. No one should have cigarettes or lighters on them.

On 8/31/16, at 1:35 p.m. R177 was observed inquiring why he had "to go outside supervised all of the sudden, why now?" when speaking with RN-A and SW-C.

On 8/31/16, at 3:03 p.m. R177 was interviewed about smoking at the facility and stated "I can't go outside here, they took my cigarettes and I can't go outside."

On 9/1/16, at 10:35 a.m. SW-C was interviewed regarding R177 smoking unsupervised. SW-C stated that smoking materials were kept locked up and whomever passed out the materials was responsible to know who required supervision for smoking and who was allowed to smoke independently. When asked if she was aware R177 had been keeping his own cigarettes she replied "I don't doubt that he keeps his cigarettes on him" and confirmed R177's smoking materials were confiscated on 8/31/16.
R101's diagnoses included malignant neoplasm of brain, major depressive disorder, anxiety, quadriplegia, muscle wasting and atrophy based on the admission record dated 4/4/16.

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F 323	Continued From page 48 On 8/30/16, at 11:06 a.m. R101 sat in the electric wheelchair with head tilted back. R101 was sitting on the side walk in front of the main entrance to the facility smoking without staff supervision. On 8/30/16, at 3:07 p.m. R101 was observed in her electric wheelchair parked by the stop sign across the therapy entrance by the facility main entrance. R101 was smoking independently tilted back in the wheelchair. At 3:10 p.m. R101's family member was observed walk out of the facility main entrance toward the side walk as R101 continued to smoke. On 8/30/16, from 5:08 p.m. to 5:26 p.m. R101 was observed smoking unsupervised on the side walk in front of the building with two other residents. On 8/30/16, at 7:03 p.m. R101 was observed to wheel out of the facility main entrance to the side walk in front of the building. R101 had a cigarette in her mouth. At 7:05 p.m. several residents stood or sat on their wheelchairs smoking. A 7:34 p.m. R101 remained in the area continued to smoke un-supervised. At 7:41 p.m. R101 and three other residents remained unsupervised on the side walk. R51 lit R101's cigarette after another resident held the cigarette to R101's mouth. At 7:45 p.m. licensed social worker (LSW)-B approached the side walk and spoke to the residents. At 7:48 p.m. R101 was observed wheel into the building behind LSW-B. On 8/30/16, at 7:07 p.m. LPN-C stated if residents were assessed as safe to be out on their own (unsupervised) they signed out at the front desk, got cigarettes from the smoking cart	F 323		

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and left the facility. LPN-C further stated if a resident was smoking at the patio they were supposed to get cigarettes from the smoke cart and no resident was supposed to have cigarettes or a lighter on them.

On 8/31/16, at 8:38 p.m. when asked about the facility smoking policy, the ED and DON stated "we have a sign out sheet, we felt we would be restricting rights if they have an unsupervised order from the nurse practitioner. At that point, we felt if they are signing themselves out, we have to give them their belongings back and let them leave the facility. During the day, the receptionist has the cart and is responsible for residents signing out and she gives them their smoking materials." Both acknowledged they had observed R101 smoking outside on 8/30/16, "We talked to her and are sending out a memo to all residents that they cannot assist other residents to smoke." Both indicated the facility property was where the sidewalk started and the facility was not responsible if residents were in the street smoking. When asked who was responsible for checking in smoking items both indicated the facility did not have anyone.

R101's fall/injury assessment care plan dated 4/1/16, indicated resident was a dependent smoker. Goal "will be free from serious injury related to smoking with personal care assistant [PCA]" The care plan directed smoking materials would be kept at nursing station, monitoring compliance to smoking policy and PCA was to assist with smoking. The care plan did not address who was responsible for assisting R101 with smoking when the PCA was not at the facility.

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R101's Smoking Safety Data Collection and Assessment dated 4/1/16, indicated resident was a dependent smoker with PCA assisting. The assessment did not address situations when resident PCA was not at the facility who was supposed to help/supervise with smoking.

On 9/2/16, at 8:35 a.m. RN-C stated R101 was a supervised, dependent smoker who had the PCA bring her outside for smoking. When asked who supervised R101 when the PCA was not at the facility RN-C stated the resident was supposed to follow the scheduled supervised smoking times allowed by the facility. RN-C further stated if a resident was not able light their own cigarette they would be supervised. Another resident was not supposed to assist with lighting it or holding it for them.

R16's quarterly Minimum Data Set (MDS) dated 7/8/16, indicated the resident had severely impaired cognition, but did not display behavioral issues.

On 8/30/16, at 7:28 p.m. R16 was observed smoking in the facility lower level smoking are. When approached, R16 stated he had been accused of smoking in his room and smoking near oxygen. "I feel I'm being watched unfairly, no one else gets watched."

On 8/31/16, at 6:26 a.m. R16 was observed in front of the building seated in his wheelchair outside on the side walk smoking unsupervised. At 6:30 a.m. the DON was observed to walk out of the building to speak briefly with R16 and return to the building. R16 continued to smoke. At 6:40 a.m. LPN-C wheeled R16 into the building.

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F 323	Continued From page 51 On 8/31/16, at 6:45 a.m. the DON again stated R16 was to be supervised when smoking and stated, "I had a talk with him." When asked where R16 had obtained the smoking materials the DON stated "probably from another resident." At 6:55 a.m. LPN-C stated R16 required supervision to smoke and had violated the facility smoking policy. LPN-C further stated the facility was currently working with the LSW for R16's placement in a facility with in-door smoking room. At 7:16 a.m. LPN-C when a resident was considered a supervised smoker it meant on a leave of absence (LOA) they could go out to the street and smoke. She indicated the facility did not have "per sea" a supervised smoking program. R16's Smoking Safety Data Collection and Assessment dated 8/2/16, indicated the resident had history of smoking in his room and not designated areas. The assessment did not indicate resident was a dependent supervised smoker rather it indicated R16 was non-compliant with the smoking policy. Although the assessment indicated resident was non-compliant it did not indicate if the resident had been given risk verses benefit education. R16's care plan dated 4/1/16, indicated resident had congestive heart failure (CHF), COPD, respiratory failure, and tracheostomy. Fall/injury care plan assessment dated 5/11/16, indicated R16 smoked and had been smoking in the room for the second time on 5/11/16. The care plan directed to keep smoking materials at the nursing station. The care plan did not indicate if resident was independent or dependent when smoking even though R16 had been identified as non-compliant, had smoking supplies with him,	F 323		

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F 323	Continued From page 52 and had smoked in the room. The facility Smoking Safety policy effective July 2015, directed: "Supervision of the Resident Smoking · Smoking only in designated area · Supervising residents who need supervision · Limiting the accessibility of matches and lighters by the resident who needs supervision" MN Smoking policy effective July 2015, directed "3. All residents who smoke may only smoke in a designated smoking area. 7. All residents who smoke and who are assessed to be "Dependent" smokers will have all their smoking materials (matches, lighters, other sources of ignition, cigarette, electronic cigarettes, cigars, pipes, tobacco and/or other inhaled tobacco substitutes) stored in a secure area at the nurses station".	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 325	1. Resident #16 and #106 weights have	10/12/16

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F 325	Continued From page 53 review, the facility failed to maintain acceptable parameters of body weight for 2 of 3 residents (R16, R106) reviewed for weight loss. Findings include: R16 reported on 8/30/16, at 7:28 p.m. he had resided at the facility since the previous winter. R16 explained that the speech therapist would not let him eat and he was fed via a tube feeding. "I eat and drink when I get a chance. They are supposed to get me in for a swallow study. I had aspiration pneumonia and was at the hospital." R16's nutrition care plan dated 4/4/16, indicated R16 was nutritionally at risk related to cardiac disease, and was at risk for dehydration secondary to diabetes type II. Care plan goal was "weight will remain stable +/-3%." Care plan directed staff to provide diet as ordered, nothing by mouth (NPO), supplements were ordered and weights monitored as needed (PRN) per protocol. The nutrition progress note dated 4/8/16, indicated R16 was to be followed up monthly for tube feeding tolerance and weight stability. Nutrition note dated 4/14/16, indicated resident was not meeting the estimated nutrition and hydration secondary to resident discontinuing himself from the tube feeding pump during the day to smoke. Resident had agreed to change the feedings to bolus to help ease compliance of tube feeding. The Nutrition Risk Data Collection and Assessment completed 7/18/16, indicated R16 had refused a weight in July and continued on bolus tube feeding four times daily. However, it did not indicate risk and benefits had been reviewed with R16.	F 325	been obtained and monitored by the dietician. A nutritional assessment has been completed. The residents care plan is reflective of goals and interventions obtained by these tools. 2. Residents' weights are obtained and are reviewed monthly or more frequently accordinlgy to their needs. Residents at nutritional risk for weight loss have been reviewed and interventions are implementd and care plans are updated as appropriate. 3. Staff has been educated on weights being obtained, notification of weight loss, and potential care plan interventions specifically related to chages in weight by 10/12/2016. 4. Director of Nursing/Designee will audit 10 resident weights per week to ensure completion. Director of Nursing/Designee will audit 3 residents nutritional assessments/care plans per week to ensure accuracy and interventions in place. Audits will be completed weekly for 1 month. Then 5 per month until discontinued by QAPI. Audit results will be shared at QAPI.	

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R16's nutrition Care Area Assessment (CAA) dated 4/18/16, indicated the resident had dysphagia, was to have nothing by mouth and received tube feedings.

R16's diagnoses included dysphagia oropharyngeal phase, gastrostomy, tracheostomy, hypothyroidism, anemia and diabetes type II obtained from the quarterly Minimum Data Set (MDS) dated 7/8/16. In addition the MDS indicated R16 received tube feedings, and "No or unknown" for loss of five percent (%) or more in the last month or loss of 10% or more in last six months with no weights recorded in the MDS.

During document review it was revealed:
-R16 had no condition or chronic disease that may result in a life expectancy of less than 6 months
-Was not on a planned weight loss program
-Had a 18 pounds (lbs) weight loss between the closest weight to survey and most recent re-admission weight which was a 9.7% weight loss.
-Vital Signs--Individual Resident Flowsheet revealed no weights had been obtained or documented on admit 11/18/16, through 4/1/16.
-4/2/16, weight was 199.8 lbs
-4/7/16, weight was 202.0 lbs
-4/11/16, weight was 202.6 lbs
-May 2016 no weights obtained
-June 2016 no weights obtained
-7/7/16, refused weight
-8/30/16, weight was 185.6 lbs obtained after surveyor requested R16 to be weighted.

On 8/30/16, at 11:40 a.m. the consultant registered dietitian (RD) acknowledged it had

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been a struggle getting residents when asked about the multiple missing weights in the medical record. The RD stated she was doing assessments without weights and had to document weights were not obtained or refused. The RD stated she started working at the facility in 4/16. The RD indicated she had sent e-mails about the weight issues weekly to corporate, including the executive director (ED) and director of nursing on about the issue. The RD further stated "I need other departments to jump on board so we can get this issue resolved." The RD acknowledged nutritional assessments and MDS's were not accurate because weights were unavailable.

On 8/30/16, at 11:44 a.m. licensed practical nurse (LPN)-C stated she had two months when obtaining the weights had been successful, however it had become a problem again and they would try again in September.

On 9/1/16, at 2:33 p.m. the RD stated she did not know why R16 had a gastrostomy tube. When asked why a swallowing study had not been completed, the RD replied, "I believe he went to the 'trach people' and was told his trach would never be removed when [R16] was in the transitional care unit [TCU]." When asked if R16's weight was supposed to be monitored monthly, the RD stated "I would like to keep up with it." The RD acknowledged a hindrance to monitoring residents was learning the new role and balancing her time between two facilities. The RD stated she had probably noticed the missing weights at the time and went to work on another resident/chart and never got back to it. The RD stated the resident "fell through the cracks."

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When asked if R16 had sustained a weight loss RD stated she should have been notified of the weight loss between the 4/11/16, and 8/30/16, weights. The RD stated she would have expected the nurse documenting the weight to have provider her with updates. The RD further stated R16 was at a high risk for malnutrition and she would have re-evaluated the current interventions since she had identified the 9.7% weight loss.

On 9/1/16, at 4:10 p.m. the nurse practitioner (NP) stated she would have expected the RD to monitor R16's weights closely due to R16's high risk for nutritional issues because of the diabetes and refusing tube feeding. The NP stated she had received a call from one of the nurses at the facility indicating R16's tube feeding type had run out and the facility needed an order for a different brand. The NP stated prior to giving the recent tube feeding order she had requested R16 to be seen by RD but was told the RD had not seen R16 yet.

The facility Enteral Tube Feeding policy dated 7/15, indicated the dietitian was to review/evaluate changes in conditions such as weight loss, discuss intolerance and/or concerns with nursing staff such as weight loss, recommend changes to the physician as needed to improve/stabilize resident nutritional status, monitor the interventions and effectiveness and to educate the resident and family as needed during each assessment and reassessment.
R106's quarterly MDS dated 7/16/16, revealed diagnoses including anemia and a mood disorder. R106 needed set up at meals, was independent with eating, and had no weight loss issues.

R106's Nutrition Risk Assessment dated 7/27/16,

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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, cereal in a bowl and a regular plate. No staff assistance was provided with eating. The dietary card indicated a divided plate with raised sides should be provided for R106.

On 8/31/16, at 8:30 a.m. dietary staff (DS)-A stated cards for each person with assistive

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F 325	Continued From page 58 devices are on the cart, but were not always accurate. On 9/1/16, at 12:20 p.m. the RD stated obtaining weights had been on ongoing issue. She had asked for weights to complete nutrition assessments and not received them. Regarding the weight for R106, the assessment did not address weight loss. If it had, she would have asked for a reweigh and assured the loss was accurate. She stated that meal observations were not a normal part of the assessment. Adaptive equipment would be recommended by therapy if a resident attended. The weight loss and weight of 148 lbs. had not been brought to her attention. The RD stated the oral surgeries would have been addressed in the care plan by nursing. R106's current care plan dated 7/21/16, did not have weight loss as a concern and did not identify R106's tooth extractions. The care plan did not include the adaptive equipment for eating, and noted R106 was independent with eating. The facility's 7/15, Weight Loss policy indicated when significant weight loss was identified the interdisciplinary team would determine interventions based on the resident's individual cause of weight loss and these interventions were to be added to the resident's care plan.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate	F 329		10/12/16

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TEXAS TERRACE CARE CENTER	7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426

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F 329	Continued From page 59 indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor target 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: R37 was observed on 8/31/16, at 8:46 a.m. at the nursing station talking on the phone. The resident was appropriate and calm. After the conversation, R37 returned to her room and shut the door. From 9:00 a.m. to 11:00 a.m. was lying in bed. The care plan for R37's mood and behavior	F 329	1. Resident #37 has been given consent for Seroquel, her behaviors have been reviewed, and residents NP has been updated, her orhtostatic blood pressure has been obtained. 2. Residents with psychotropic medications have had their behaviors reviewed and documented on their behavior care plan upon admission, quarterly, and with signficant changes. Residents with current psychotropic medication usage have been reviewed and have been give consent and have their orthostatic blood pressure taken on a monthly basis. 3. Unit Managers, License Nurses and the	

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F 329	Continued From page 60 symptoms assessment dated 11/10/15, indicated the resident had a potential for side effects from psychotropic drug use. The care plan identified R37 used Trazodone for depression and Seroquel for traumatic brain injury with cognitive decline. The care plan directed staff to monitor for hypotension (sudden drop in blood pressure with rising, common with psychotropic medication use), behavior and cognitive impairment deterioration. A psychotropic drug use Care Area Assessment (CAA) for R37 dated 11/19/15, indicated the resident used Seroquel and Trazodone. In addition, the CAA indicated R37 had potential for adverse effects from medications and directed to review the care plan for interventions. R37's physician orders dated 6/6/16, revealed orders for the antipsychotic, quetiapine fumarate (for Seroquel) 25 mg twice daily for dementia with behavioral disturbances and the antidepressant commonly used to promote sleep,Trazodone 150 mg at bedtime for depression. R37's diagnoses included dementia, traumatic 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. On 8/31/16, at 12:23 p.m. LPN-A stated R37 had the behavior of cursing out but did not strike out at others. At times she cursed at staff, but when re-approached an hour or so later she would be pleasant. LPN-A further stated R37 had a good support system and would use the phone to talk with family. She did not think R37 was depressed.	F 329	Social Services Department has been educated on documenting behaviors on the behavior care plan, on providing residents with consent sheets when utilizing medications, and monitoring of orthostatic blood pressure by 10/12/2016. 4. Director of Social Services/designee to audit 5 residents per week to ensure target behaviors and behavior care plans are documented and consistent with goals of psychotropic medications. Director of Nursing/designee to audit 5 residents per week to ensure orthostatic blood pressure are completed monthly and consents are given to residetns appropriately. Audits will be completed weekly for 1 month. Then 5 per month until discontinued by QAPI. Audit results will be shared at QAPI.	

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On 9/1/16, at 6:45 a.m. LPN-B stated R37 had never had any physical behaviors of hitting, kicking or harming self or other that she was aware of. LPN-B indicated the resident was very verbally aggressive toward staff, depending if they had established a rapport with her.

On 9/1/16, at 9:31 a.m. LPN-C stated R37's chart did not have a Seroquel consent for medication use and R37 had no behavior monitoring in place. In addition, LPN-C stated no orthostatic blood pressures were obtained in the last three months further stating "They are supposed to be done at least once a month for psychotropic medication use."

On 9/1/16, at 10:06 a.m. licensed social worker (LSW)-A acknowledged behavior monitoring had not been completed for R37 for the last 90 days. LSW-A stated the staff had documented behavior on only one occasion. LSW-A acknowledged no one had been tracking the documentation to ensure behavior monitoring was being completed. LSW-A further stated the social services department had just filled the positions which would help closely audit and review documentation of behavior moving forward.

On 9/1/16, at 4:09 p.m. R37's nurse practitioner (NP) stated she would have expected the staff to complete behavior tracking and trending as R37 had occasional psychosis. The NP had discussed with R37 that medications were for the resident's comfort and well being. The NP further stated she would have expected the staff to monitor orthostatic blood pressure for a resident on antipsychotic medication per facility protocol because of the potential for orthostatic hypotension with Seroquel and Trazodone use.

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F 329	Continued From page 62 On 9/1/16, at 4:24 p.m. the director of nursing stated she also would have expected the behaviors to be monitored and orthostatic blood pressures to be checked monthly.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal	F 334		10/12/16

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F 334	Continued From page 63 immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a policy and procedure related to the pneumococcal conjugate vaccine (PCV13) according to recommendations by the	F 334	1. Resident #64 has been ordered and offered PVC13. Currently, waiting for spousal consent. 2. Resident's upon admission and	

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F 334	Continued From page 64 Centers for Disease Control (CDC) for 1 of 5 residents (R64) whose vaccination histories were reviewed. Findings include: R64's Immunization Record dated 7/28/09, indicated the 79 year old resident received the Pneumovax in 2007. There was no evidence he had been offered the PCV13 vaccine since his admission to the facility in 2007. 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." On 9/2/16, at 8:00 a.m. the director of nursing (DON) stated the new guidelines for updating pneumococcal vaccines had been partially implemented in the facility. The DON stated R64 had not received an updated vaccine. The facility's 7/16, vaccination policy indicated "All adults 65 years of age or older receive a dose of PCV13 followed by a dose of pneumococcal polysaccharide vaccine (PPSV23) at least 1 year later."	F 334	annuallly will be reviewed for immunization needs. Resident's pneumococcal audit has been completed and residents whom have not received PCV13 have been offered the immunization. 3. Licensed nurses have been educated on the administration of PCV13 by 10/12/2016. 4. Director o f Nursing/designee will audit 3 residents per week for one month to ensure they have been informed/offered pneumococcal appropriately. Then 3 per month unitl discontinued by QAPI. Audit results will be shared at QAPI.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name.	F 356		10/12/16

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F 356	Continued From page 65 o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the staff posting was correct for the number and types of staff providing care in the facility. This had the potential to affect all 101 residents in the facility. Findings include: On 8/28/16, the staff posting inaccurately	F 356	1. Staffing hours will be posted in prominently visible resident area on a daily basis including facility name, current date, and the total # of hours and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care. Facility Executive Director will ensure accuracy in daily postings. 2. Staffing coordinator, NHA, DON, and	

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F 356	Continued From page 66 reflected the number of registered nurses (RN), licensed practical nurses (LPN), and trained medication assistants (TMA) working. In addition, the full time equivelent (FTE) was calculated incorrectly. For example, on the evening shift the nursing assistants (NA) were listed as 12 FTE, when the actual hours worked totaled 81 hours versus 96 hours, as the NAs had worked partial shifts. Additional staff postings reviewed included: The 6/1/16, staff posting inaccurately reflected the number of RNs, LPNs, and TMAs working and had not been updated with changes. In addition, the FTE was calculated incorrectly. For example on the evening shift the NA's were listed as 11 FTE, when the actual hours worked totaled 75 hours, not 88 hours. 11 NA's worked partial shifts, not 11 FTE of NA's. [1 FTE= 80 hours, 10 employees working 8 hour days would = 1 FTE]. However, the facility used partial shifts 6.0, 7.3, and 7.5 shifts, but then counted partial shifts as full. The 6/2/16, staff posting was not accurate for the number of RN, LPN, and TMA working and had not been updated with changes. In addition the FTE was calculated incorrectly, for example, on the evening shift the NA's were listed as 10 FTE, when the actual hours worked totaled 69, or .86 FTE, 10 people worked partial shifts, not 10 FTE (four of the 10 people worked only 6 hour shifts and 6 worked 7.5 hour shifts). The 6/8/16, 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	F 356	Business Office Manager have been educated about calculating FTE's for the daily staffing sheet by 10/12/2016. 3. Business Office Manager/Designee will audit daily staffing sheets on weekly basis to ensure accuracy of FTE calculation and of census. Results of daily audit will be shared in QAPI. Daily audits performed for one month. QAPI committee will determine legnth of time audits are neeed.	

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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

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F 356	Continued From page 68 managers and the assistant nurse managers time would be included in the posting even though the were not providing direct care.	F 356		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441		10/12/16

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F 441	Continued From page 69 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control measures were used during cares for 1 of 1 resident (R120) reviewed for tube feeding and 3 of 3 residents (R172, R75, R39) reviewed for wound treatments. Findings include: R120 had a gastrostomy tube. On 8/31/16, at 9:00 a.m. registered nurse (RN)-D was set up R120's medications. At 9:17 a.m. RN-D washed her hands in R120's room and applied gloves. RN-D touched the gauze dressing around R120's G-tube site which was soiled with dried blood. RN-D continued to check tube placement then administered the medications mixed together. RN-D was observed give 30 milliliter (ml) water flushes to R120 after two rounds of medications. On the second water flush the syringe and G-tube disconnected and stomach fluid was observed to come out of the G-tube. RN-D quickly re-connected the tube and finished the flush. RN-D removed her gloves after the water flushes and medications and reapplied another pair without washing her hands. At 9:30 a.m. RN-D removed the gloves and walked out of the room holding the pair of gloves she had removed. RN-D did not wash her hands. RN-D was stopped by the surveyor at this time. RN-D acknowledged she had not washed her hands prior to leaving the room or when she removed the first pair of	F 441	1. Residents #39, #75, #172, and #120 have had cares provided for them per appropriate infection control guidelines for hand hygiene. Resident #172 has discharged home successfully. 2. Identified staff have completed one on one education regarding appropriate infection control procedures for each witnessed incident. Residents with multi drug resistant organisms infection of wounds have been placed on appropriate precautions. 3. Licensed nurses will be educated on infection control practice for g-tube and wound care duties by 10/12/2016. 4. DON/Designee will audit 1 g-tube and 2 wound dressings per week for one month to ensure/teach appropriate infection control measures with the staff. Then 1 g-tube, 2 wound dressings per month until discontinued with QAPI. Results of audit will be shared at QAPI.	

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gloves after administering the medications and flushes.

On 9/1/16, at 9:38 a.m. licensed practical nurse (LPN)-C stated she would have expected the staff to change gloves between cares, wash hands between gloves changes and before leaving the room.

On 9/1/16, at 4:23 p.m. director of nursing (DON) stated staff was supposed to wash hands after removing gloves and before re-applying another pair between cares.

R172's Physician's Orders on discharge from the hospital dated 8/25/16, included an order for wet to dry dressing change twice a day, and a diagnosis of infected ulcer of skin with necrosis of muscle. The hospital discharge notes indicated an infected coccygeal ulcer with contact precautions implemented on 8/24/16, and treatment with Vancomycin (antibiotic) 1,000 milligrams intravenously at dialysis.

R172's Minimum Data Set (MDS) dated 7/28/16, indicated R172 was cognitively intact, had no memory issues and had an unstageable wound on the coccyx.

R172 was observed on 8/30/16, at 11:00 a.m. R172 had a open deep wound to the coccyx. R172 stated she washed it out and was waiting for the nurse to dress the wound. The wound had a dry washcloth on it. R172 removed the washcloth and a large tunneling wound on the coccyx was observed.

On 9/1/16, at 11:40 a.m. R172's dressing change was observed. R172 did not have a dressing in

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place and said she washed the wound herself after an incontinent episode. R172 stated the wound had been soiled. R172 had a dry washcloth in place on the wound. RN-A stated she was not familiar with R172, but was helping out. R172 stated RN-A did not have the correct solution to clean the wound, and the resident redirected her to get the "blue bottle."

RN-A washed her hands and applied gloves then cleansed the wound with wound cleaner on gauze. RN-A packed wound with wet gauze and covered it with Alleyvn (an occlusive dressing). The nurse threw the soiled gloves and wrappers on the floor and said she would pick up them up later. After completing the dressing change RN-A removed her gloves, washed her hands, then picked up the soiled gloves and paper wrappers from the floor. Without gloves RN-A picked up the soiled gloves and wrapper from the floor and placed them in the garbage can. RN-A did not wash her hands, then gathered the wound supplies, pushed back the curtain, and left the room.

On 9/2/16, at 8:10 a.m., the director of nursing (DON) stated R172 had recently been hospitalized for a wound infection. The wound had been cultured for Methicillin-resistant Staphylococcus Aureus (MRSA-antibiotic resistant bacteria). She stated she was unaware R172 removed the occlusive dressing on her own and used a washcloth to cover the wound. The DON acknowledged contact precautions would have been implemented if a wound had MRSA and was not covered with an occlusive dressing. The DON also stated nurses should have bagged all soiled gloves, dressings, and laundry at the time of removal and not allow them to fall to the

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	245187	A. BUILDING _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 72	F 441		

floor.
R75 was admitted to the facility with a non-pressure chronic heel ulcer. R75's admission minimum data set (MDS) assessment dated 6/10/16, identified R75 was admitted with two unstageable pressure ulcers. The assessment indicated that ulcers were covered in eschar (black, brown or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin).

R75's careplan dated 8/9/16, indicated an unstageable right heel ulcer with black eschar. The careplan directed staff to monitor the wound weekly, elevate heels and offload the resident every shift. R75's physician orders signed 8/31/16, directed staff to "clean right heel every day, apply Medi-Honey, then cover with adaptic and gauze."

On 8/29/16, at 10:21 a.m. R75 was observed in his room, sitting in his wheelchair. R75's right foot was bare. R75's right shoe and sock was sitting on the bedside table next to R75. R75's foot was hanging off of the right wheelchair foot rest and clear, pink drainage was observed on the floor underneath the foot. A soiled gauze was on the floor next to the drainage. R75 stated that the doctor had been in to see him and he was waiting for the nurse to come and wrap the wound. At 10:25 a.m. RN-A was interviewed and was unaware the wound was not wrapped. RN-A immediately sent RN-B to dress R75's wound.

On 9/1/16, at 1:24 p.m. RN-A completed R75's dressing change. RN-A washed her hands, donned gloves and cleaned the scissor before beginning the dressing change. R75 was in his wheelchair during the dressing change. RN-A sat

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on a chair in the room and set several washcloths over her knee. She then removed R75's shoe and sock and placed his foot on the washcloths over her knee. RN-A cut the old dressing gauze and removed the dressing from R75's foot. RN-A placed the dressing in the garbage and set the scissor on the floor. Green drainage was observed on the old dressing. RN-A set another towel on the floor and placed R75's foot on the towel. RN-A took the washcloths from her knee and placed them on the floor on top of the scissor. RN-A then got up from the chair, removed her gloves, sanitized her hands with antibacterial foam, and donned new gloves. RN-A sat back down in the chair, applied clean washcloths on her knee and put R75's foot on the washcloths to continue with the dressing change. RN-A sprayed saline wash on the wound, wiped the wound with gauze and threw the gauze in the garbage. RN-A removed her gloves, donned new gloves and applied Medi-Honey on the wound bed and covered with Vaseline gauze and Kerlix to complete the dressing change. RN-A removed the washcloths from her knee and placed them on the floor. The washcloths were soiled with green drainage from the wound. RN-A then removed her gloves. Before leaving the room, RN-A kicked the washcloths around on the floor to look for the scissor. After finding scissor under the washcloths, she picked up the scissor from the floor. RN-A then stated she was going to get a linen bag to dispose of the soiled linen, leaving the room with soiled linen on the floor. RN-A was interviewed and could not state why she did not obtain the linen bag, prior to beginning the dressing change in order to avoid placing soiled linens on the floor.

R39 was observed in her room in her wheelchair

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on 8/29/16 at 12:45 p.m. R39's right leg wound was open to air without a dressing covering the wound. Clear, pink drainage was observed running down R39's leg from the wound. R39 was interviewed and stated that the wound had not been dressed today. At 2:20 p.m. R39 was observed sitting in her wheelchair by the nurses' station. R39's right leg wound was open to air, with no dressing in place. Dried drainage was observed from the wound to the residents foot. At 3:36 p.m. R39 was observed outside in her wheelchair with her right leg uncovered. Dried drainage from the wound was observed from the outside of the wound down to R39's foot. R39 explained the "dressing should have been done today" but those who usually complete the dressing change had gone home for the day.

On 8/29/16, at 3:53 p.m. R39's medication treatment sheets were reviewed. LPN-C had signed off R39's wound care for the day. At 3:54 p.m. RN-A was interviewed. RN-A stated the wound doctor saw R39 and R75 that day and the wounds should have been covered. RN-A stated she "typically does go with the wound doctor to each floor, but needed to help up on second floor." RN-A stated she usually completed the dressing change when on wound rounds. RN-A said the wound doctor told her that he had the supplies that day. When asked about R75's wound draining on to the floor, RN-A replied that there was typically a towel down on the floor for drainage, but did not know why there was not one that day.

On 9/2/16, at 8:10 a.m. the director of nursing (DON) confirmed nurses should have bagged all soiled gloves, dressings, and laundry at the time of removal and not allow them to fall to the floor.

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F 441	Continued From page 75 The DON explained that a nurse typically went with the the physician on wound rounds and had the responsibility for dressing the wounds. The facility's 7/15, Multi-drug--Resistant Organisms (MDRO) policy directed staff to "use hand hygiene upon entering and leaving a resident's room, utilize standard precautions for all residents with MDRO and implement contact precautions when indicated." The policy further indicated residents "shall be cared for under standard precautions for managing secretions/excretions (including wound drainage). Secretions/secretions are defined as contained when they do not leak out of containment products."	F 441		
F 496 SS=E	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.	F 496		10/12/16

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F 496	Continued From page 76 If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure all nursing assistants (NAs) had completed a competency testing from a valid testing agency as required. This had the potential to affect 70 residents on 1st floor and 2nd floor. Findings include: On 12/1/15, a public notice by the Minnesota Department of Health (MDH), requiring re-testing for 569 NAs for persons who were previously tested to become federally qualified NAs. This included the Inver Hills Community College Center for Professional and Workforce Development and its satellite location at Blue Sky Online in West St. Paul between May 1, 2014, and October 16, 2015. The move came after investigators found evidence of anomalies in test results associated with the two sites, raising questions about reliability. Although it was unclear which individuals who took the tests at the two locations during the time period of May 2014 to October 2015 may have	F 496	1. The staff member has been suspended indefinitely until they acquire a valid nursing assistance license. 2. Nursing assistances have been audited to ensure they have a valid nursing assistance license. 3. Human Resources director will be provided with education regarding all nursing assistances need a valid license if they are to work at Texas Terrace Care Center by 10/12/2016. 4. Business Office Manager/Designee will complete 5 audits per week of human resources files to ensure valid licenses are obtained for all current nursing assistants. Then 5 audits per month will contine until discontinued by QAPI. Results of audits will be shared at QAPI.	

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F 496	Continued From page 77 been impacted by the potential improprieties, MDH took precautions requiring re-testing for all individuals tested at those two locations during that timeframe, without cost to the individuals. NAs affected could continue to work, however, were required to re-test no later than March 31, 2016. Any individuals who did not pass the re-testing by that date would be considered ineligible to work as a NA at a federally certified nursing home or board and care home. In addition, many state licensed employers chose not to hire individuals who had not passed the re-test. NA-A had a NA competency from one of the centers listed above. A letter was sent to NA-A in 12/15, stating re-testing needed to be completed by 3/31/16. NA-A was not eligible to work in the nursing home until the tests were passed, and the NA's status was changed on Minnesota's NA Registry effective 4/1/16. The facility failed to verify all NAs affected had completed re-testing as required, and were active on the NA Registry. NA-A continued to work in the facility after inactive status from 4/1/16 through 8/19/16. NA-A worked in the facility on 9/1/16, and was scheduled to work again on 9/2/16. The facility staff reported NA-A would be removed from the schedule for 9/2/16. During an interview on 9/2/16, at 9:11 a.m. the human resources director stated she had informed the NAs who met the re-testing requirements, but should have also verified NA-A's status on the Registry.	F 496		
F 518	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY	F 518		10/12/16

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F 518 SS=C	Continued From page 78 PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to train 2 of 5 employees (E2, E3) on emergency procedures. Findings include: Employee personal files were reviewed on 9/9/16, for training in disaster and emergency preparedness. E2 was hired on 7/26/16, and E2's personal file lacked evidence of training in the facility's emergency procedures. E3 was hired on 5/3/16, and E3's personal file lacked evidence of training in the facility's emergency procedures. The human resource director was interviewed on 9/9/16, at 9:00 a.m. and confirmed there was no documentation in E2 and E3's personnel files to show emergency preparedness training had been provided. The facility's undated Fire--Long Grass policy, indicated the facility would "make every possible effort to safeguard the residents, staff, and physical environment of the facility in the event of a fire."	F 518	1. The staff memebers identified have recieved the disaster and emergency training. 2. Staff inservice records have been audited to ensure they have recieved disaster and emergency training. 3. Human resource director and field education director (reponsible for general oreitation) have been provided education that all staff need to be given disaster and emergency training before completion of general oreintation by 10/12/2016. 4. Business Office Manager/Designee will complete 5 audits per week of human resources files to ensure emergency education has been provided to all new hires. Then 5 audits per month will continue until discontinued by QAPI. Results of audits will be shared at QAPI.	
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET	F 520		10/12/16

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F 520	Continued From page 79 QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Quality Assurance (QA) committee recognized and developed an action plan to address an identified lack of supervision related to smoking for 5 of 7 residents (R16, R95, R101, R118, R177) identified as needing supervision while smoking. In addition the facility failed to improve upon practices in the areas of abuse reporting, unnecessary medications and infection control	F 520	1. QA meets on a monthly basis and identified quality issues and action plans are developed and reviewed. 2. The quality assurance committee last met on 9/23/2016. The QA committee and medical director reviewed the smoking policy/ procedure and have made changes as appropriate. The quality assurance committee also discussed the immediate safety plan for resident	

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F 520	Continued From page 80 that were identified in a previous recertification survey on 9/17/15. These practices had the potential to affect all 101 residents in the facility. Findings include: Refer to F323: the facility failed to provide adequate supervision for 5 of 7 residents (R16, R95, R101, R118, R177) who were identified as unable to safely leave the facility unsupervised to smoke. During an interview on 8/31/16, at 8:38 a.m. the executive director (ED) stated residents who had a physician's order allowing them to leave the facility unsupervised were allowed to stand out on the sidewalk in front of the facility to smoke. He stated the residents were to sign out their smoking materials before going outside, however, there was currently no plan in place to check the smoking materials when the residents returned to the building. The ED stated for residents not assessed as safe to smoke unsupervised could smoke during allotted times in the supervised smoking area outside the lower level. The ED further stated he was aware some residents who did not have an order to leave the facility had been observed smoking on the sidewalk unsupervised during the survey. Refer to F225 and F226: the facility failed to immediately report allegations of abuse to the designated State agency (SA) as required and in accordance with facility policy for 4 of 5 residents (R19, R29, R40, R75) who alleged mistreatment by facility staff. Refer to F329: The facility failed to implement appropriate monitoring for the use of psychotropic	F 520	abuse/neglect and its current implmentation. The next QA meeting is scheduled for 10/12/2016 where review of unnecessary medication concerns and infection control concerns will be discussed along with all other deficiencies from the current survey and the plan of correction to fix above deficiencies from the current survey and the plan of correction to fix above deficiencies. 3. DCS/designee will audit monthly QA minutes to ensure implementation and follow through has been documented and executed for action plans and performance improvement plans. Executive Director/ designee will forward QAPI audits to the monthly QAPI committe monthly for 3 months for continued opportunities for improvement.	

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F 520	Continued From page 81 medications. Refer to F441: The facility failed to implement appropriate infection control measures to reduce the risk of infection during wound care. A facility policy regarding quality assurance was requested but none was received.	F 520		

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITIES POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on September 01, 2016. At the time of this survey, Texas Terrace Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid, 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:

EPOC

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Texas Terrace Care Center is 3-story building with no basement. The original building was constructed in 1972 and was determined to be of TYPE I(332) Construction. In 1995 an addition was constructed to the west and it was determined to be of TYPE I(332) Construction. It is automatic fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 118 beds. At the time of the survey the census was 97.	K 000		
K 029 SS=E	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system	K 029		10/16/16

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	245187	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/01/2016**

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TEXAS TERRACE CARE CENTER	**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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 2 option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on a facility tour and staff interview, the facility failed to provide protection of hazardous areas in accordance with the requirements of NFPA 101 -2000 edition, Section 19.3.2.1 and 8.4.1. This deficient practice could affect all residents within the smoke compartment. Findings include: On a facility tour between the hours of 09:00 AM 01:00: PM on September 01, 2016, observation revealed that the Staffing Central Supply room had a large amount of combustible storage, but did not have a self-closing door. This deficient practice was verified by the Administrator at the time of inspection.	K 029	1. A self closing door will be installed to the Staffing Central Supply room. 2. The self closing door was installed on October 14th, 2016. 3. The Director of Maintenance will be responsible for ensuring the installation occurs and the unit operates appropriately moving forward.	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility has not been documenting sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 (99), Sec. 7-3.2.1. This deficient practice could affect all 97 residents. Findings include:	K 054	1. The facility conducted and documented a smoke detector sensitivity test. 2. The smoke detector sensitivity test was completed on October 12th, 2016. 3. The Director of Maintenance is responsible for scheduling smoke detector sensitivity tests in accordance	10/16/16

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K 054	Continued From page 3 On a facility tour between the hours of 09:00 AM and 01:00 PM on September 01, 2016, observation revealed that the facility could not provide documentation of a current smoke detector sensitivity test. This deficient practice was verified by the Administrator at the time of inspection.	K 054	with the manufacturer's specifications.	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on observations and staff interview, the automatic sprinkler system is not installed and maintained in accordance with NAPA 13 the Standard for the Installation of Sprinkler Systems 1999 edition. The failure to maintain the sprinkler system in compliance with NAPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect all 97 residents. Findings include: On a facility tour between the hours of 09:00 AM	K 056	1. Upon review of documentation, in conjunction with Viking Automatic Sprinkler Company, the facility had four quarterly reports on file but no annual report. The facility spoke with Inspector Dan Archibald of Viking Automatic Spinkler Company who reports that Texas Terrace is scheduled for annual inspection in quarter one of each year. Viking Spinkler Company sent a report dated 3/16/2016 that they did complete an annual inspection. 2. The facility was able to obtain the annual report on October 7th of 2016. 3. The Director of Maintenance is	10/16/16

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K 056	Continued From page 4 and 01:00 PM on September 01, 2016, observation revealed that the facility could not provide documentation for a current annual automatic fire sprinkler inspection. This deficient practice was verified by Administrator at the time of inspection .	K 056	reponsible to monitor and schedule all spinkler inspections.	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observations, document review and staff interview, the facility failed to follow the policy for smoking in accordance with NFPA LSC (00) Edition Section 19.7.4. Findings include:	K 066	1. For clarification, cigarrette butts were discareded in a trash receptacle that is outside of the facility. The facility does not allow smoking inside the facility at any time. However, the trash receptacle outside the back door of the facility is not	10/16/16

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K 066	Continued From page 5 1. On a facility tour between the hours of 09:00 AM and 01:00 PM on September 01, 2016, observation revealed that there were cigarette butts discarded in a trash receptacle outside the boiler room. This area was not a designated smoking area. This deficient practice was verified by the Administrator at the time of inspection.	K 066	a designated smoking area. The facility has posted a memo reminding employees of appropriate areas where smoking allowed. The facility has also removed the trash receptacle to relieve staff of the tempation of discarding cigarette butts within trash can. The facility has added appropriate receptacles where employees are permitted to smoke. 2. The memo, removal of garbage can, and addition of new cigarette receptacles occured on 10/14/2016. 3. The facility Director of Maintenance will be responsible for monitoring trash receptacles and the facility Administrator will be responsible for ensuring staff smoking in permitted areas.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

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

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

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

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

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

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

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On 9/2/16, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. In addition, an investigation of complaint, H5187072 was completed. The complaint was not substantiated.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality committee (QC) recognized and developed an action plan to address an identified lack of supervision related to smoking for 5 of 7 residents (R16, R95, R101, R118, R177) identified as needing supervision while smoking. In addition the facility failed to improve upon practices in the areas of abuse	2 255	Corrected.	10/12/16

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2 255	Continued From page 3	2 255		

reporting, unnecessary medications and infection control that were identified in a previous recertification survey on 9/17/15. These practices had the potential to affect all 101 residents in the facility.

Findings include:

Refer to F323: the facility failed to provide adequate supervision for 5 of 7 residents (R16, R95, R101, R118, R177) who were identified as unable to safely leave the facility unsupervised to smoke.

During an interview on 8/31/16, at 8:38 a.m. the executive director (ED) stated residents who had a physician's order allowing them to leave the facility unsupervised were allowed to stand out on the sidewalk in front of the facility to smoke. He stated the residents were to sign out their smoking materials before going outside, however, there was currently no plan in place to check the smoking materials when the residents returned to the building. The ED stated for residents not assessed as safe to smoke unsupervised could smoke during allotted times in the supervised smoking area outside the lower level. The ED further stated he was aware some residents who did not have an order to leave the facility had been observed smoking on the sidewalk unsupervised during the survey.

Refer to F225 and F226: the facility failed to immediately report allegations of abuse to the designated State agency (SA) as required and in accordance with facility policy for 4 of 5 residents (R19, R29, R40, R75) who alleged mistreatment by facility staff.

Refer to F329: The facility failed to implement

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2 255	Continued From page 4 appropriate monitoring for the use of psychotropic medications. Refer to F441: The facility failed to implement appropriate infection control measures to reduce the risk of infection during wound care. A facility policy regarding quality assurance was requested but none was received. SUGGESTED METHOD OF CORRECTION: The quality committee could review their system for identifying quality deficiencies to ensure systems issues are identified and addressed. The committee could track progress to ensure resolution to problems. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
2 300	MN Rule 4658.0105 Competency A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure all nursing assistants (NAs) had completed a competency testing from a valid testing agency as required. This had the potential to affect 70 residents on 1st floor and 2nd floor.	2 300	Corrected	10/12/16

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2 300	Continued From page 5 Findings include: On 12/1/15, a public notice by the Minnesota Department of Health (MDH), requiring re-testing for 569 NAs for persons who were previously tested to become federally qualified NAs. This included the Inver Hills Community College Center for Professional and Workforce Development and its satellite location at Blue Sky Online in West St. Paul between May 1, 2014, and October 16, 2015. The move came after investigators found evidence of anomalies in test results associated with the two sites, raising questions about their reliability. Although it was unclear which individuals who took the tests at the two locations during the time period of May 2014 to October 2015 may have been impacted by the potential improprieties, MDH took precautions requiring re-testing for all individuals tested at those two locations during that timeframe, without cost to the individuals. NAs affected could continue to work, however, were required to re-test no later than March 31, 2016. Any individuals who did not pass the re-testing by that date would be considered ineligible to work as a NA at a federally certified nursing home or board and care home. In addition, many state licensed employers chose not to hire individuals who had not passed the re-test. NA-A had a NA competency from one of the centers listed above. A letter was sent to NA-A in 12/15, stating re-testing needed to be completed by 3/31/16. NA-A was not eligible to work in the nursing home until the tests were passed, and the NA's status was changed on Minnesota's NA Registry effective 4/1/16.	2 300		

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2 300	Continued From page 6 The facility failed to verify all NAs affected had completed re-testing as required, and were active on the NA Registry. NA-A continued to work in the facility after inactive status from 4/1/16 through 8/19/16. NA-A worked in the facility on 9/1/16, and was scheduled to work again on 9/2/16. The facility staff reported NA-A would be removed from the schedule for 9/2/16. During an interview on 9/2/16, at 9:11 a.m. the human resources director stated she had informed the NAs who met the re-testing requirements, but should have also verified NA-A's status on the Registry. SUGGESTED METHOD OF CORRECTION: The director of nursing or human resources staff could devise a NA Registry verification system. Staff not on the Registry would not be scheduled. Audits could be conducted and the result brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 300		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b).	2 560		10/12/16

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2 560	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a care plan for 1 of 2 residents (R95) who had been hospitalized for alcohol intoxication and was known to use illegal substances in the facility. Findings include: Review of R95's medical record progress notes included the following: A social service note dated 6/6/16, indicated, "SW [social worker] was informed that resident was found in a room rolling marijuana as cigs [cigarettes]. Smoking/Drugs policy was reviewed with resident." A social service note dated 6/7/16 read, "Resident was hosp. for BS due to ETOH[hospitalized for blood sugar due to alcohol] abuse. SW disposed of the remaining drink and a room search was done." A communication form and progress note dated 6/7/16 included R95 was sent to the hospital emergency room to evaluate and treat unresponsiveness and an elevated blood sugar reading. Written in above the R95's name included the following "[R95] was smoking pot last HS [night]." A nursing note dated 6/7/16 at 3:30 p.m. included R95 was incoherent and unresponsive with a blood sugar of 533. R95's nurse practitioner (NP) was called and provided an order for STAT [immediate] 10 units of Novalog insulin and to send to the emergency room for an evaluation.	2 560	corrected	

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TEXAS TERRACE CARE CENTER	7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426

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2 560	Continued From page 8 On 6/8/16, an interdisciplinary team note indicated the resident was hospitalized 6/7/16 for hyperglycemia and alcohol intoxication. R95 returned five hours later with no new orders. A social service note dated 6/25/16, read "Resident's care plan and assessments were reviewed with social worker, community police, guardian and resident. Review of the THC [drug] use over the weekend. Resident admitted to using and reported the source. Resident agreed not to repeat this behavior". A psychology referral was also set up by the licensed social worker (LSW). A nursing noted dated 6/26/16 at 3:00 p.m. R95 was "seen smoking with another resident [R118] an illegal substance. The nurse accompanied by a trained medication aide came out to the smoking are and smelled the substance. The residents were approached and asked if the substance was marijuana. The residents apologized to staff for smoking it but continued to pass it to one another. [R95] was searched and nothing found, she had no pockets and stated, 'there is no more.'" R95's NP and the director of nursing were notified. R95's careplan did not include the 6/7/16 hospitalization for alcohol use or the 6/6/16 and 6/25/16 use of marijuana. R95's cognitive testing 7/1/16, revealed the resident had moderate cognitive impairment. An interview on 9/1/16 at 9:14 a.m. with the executive director ED, DON and director of clinical services (DCS) confirmed that the care plan did not identify R95's alcohol or drug use in the facility, and that is should have been included	2 560		

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2 560	Continued From page 9 on the careplan. On 9/2/16, at 8:45 a.m. the care plan policy was requested but was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or desginee could review policies. Education of appropriate staff could be provided. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: 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	2 570	Corrected	10/12/16

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2 570	Continued From page 10 2 residents (R118) identified to possess and use illegal substances. In addition, the facility failed to update and revise the careplan for weight loss and a change in dental status for 1 of 3 (R106) reviewed for weight loss. Findings include: R95 had a cognitive assessment dated 7/1/16, indicating moderate cognitive impairment. During entrance conference on 8/29/16, at 8:04 a.m. the facility identified R95 required supervision with smoking. A smoking assessment dated 3/31/16, identified R95 as independently able to smoke. R95's careplan dated 7/15, identified R95 smoked, however did not include if supervision was required. On 8/29/16, at 10:00 a.m. R95 was observed smoking on the Garden Terrace patio (approved supervised smoking area) during non-smoking hours. The surveyor asked registered nurse (RN)-A whether the resident was supposed to be smoking on the patio. RN-A replied "no" and assisted R95 back into the building. On 8/29/16, 3:15 p.m. R95 independently wheeled outside to the front of the facility, sat in front of the mailbox and smoked a cigarette, and then returned to the building. On 8/30/16, at 7:24 p.m. R95 was observed sitting outside on the Garden Terrace patio smoking a cigarette. No staff was observed to be supervising the smoking. At 7:37 p.m. in the elevator R95's clothing and wheelchair were covered with cigarette ashes. There was a hole where the brake of the wheelchair attached that	2 570		

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2 570	Continued From page 11 was also filled with ash. Review of R95's medical record progress notes included the following: A social service note dated 8/1/16 identified "SW informed resident that there will be scheduled times for smokers to go to the patio to smoke supervised. Resident signed the smoking policy and agreed to the rules. Resident is also able to sign out to go independently to smoke if she signs out." A social service note dated 8/2/16 noted "The concern is that the resident is unable to remember or comply with staff requests. SW called guardian who agrees to allow resident to smoke 'only' during supervised scheduled times as posted on each unit. The resident and staff were informed of the restriction and change--help resident comply with change." A nursing note dated 8/6/16, at 10:30 p.m. indicated R95 was observed smoking during non-smoking hours. R95 smoked another cigarette that she received from another resident. An interview with licensed social worker (LSW)-A on 8/31/16, at 10:42 a.m. confirmed R95 was only able to smoke while supervised on the patio during smoking times and her smoking materials should have been locked in the smoking cart. 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. R177 was identified by facility staff on 8/29/16, at	2 570		

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2 570	Continued From page 12 8:07 a.m. as a resident who smoked. A smoking assessment dated 8/11/16, indicated R177 independently smoked. R177's careplan dated 8/15/16, identified the resident as alert and oriented and someone who smoked. Interventions included smoking materials were to be kept in the smoking cart, however, did not indicate whether R177 required supervision with smoking. R177 was interviewed on 8/30/16, at 2:45 p.m. and stated that he was able to smoke independently and kept his cigarettes in his room. R177 stated he signed out to smoke and left and returned as he desired. R177 stated he did not go to the patio to smoke because smoke times were limited. On 8/30/16, at 8:14 p.m. R177 was independently smoking on the sidewalk outside the facility. On 8/31/16, at 1:35 p.m. R177 was hear inquiring of RN-A and LSW-C, why he had "to go outside supervised all of the sudden--why now?" On 8/31/16, at 3:03 p.m. R177 was interviewed about smoking at the facility and stated "I can't go outside here. They took my cigarettes and I can't go outside." On 9/1/16, at 10:35 a.m. LSW-C was interviewed regarding R177 smoking unsupervised. LSW-C stated that smoking materials were kept locked up and whomever passed out the materials was responsible to know who required supervision for smoking and who was allowed to smoke independently. When asked if she was aware R177 had been keeping his own cigarettes she replied "I don't doubt that he keeps his cigarettes	2 570		

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2 570	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 on 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 independent with eating, and had no weight loss issues. R106's Nutrition Risk Assessment dated 7/27/16,	2 570		

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2 570	Continued From page 14 indicated R106 weighed 159 pounds 30 days prior 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) - 7/16, no weights available - 6/21/16, 159 lbs. (11 lbs or a 7.4% loss) - 5/16, no weights available - 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 and he drank better out of the 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. On 8/31/16, at 8:00 a.m. R106 was served breakfast, had a two-handled cup with a straw, cereal in a bowl and a regular plate. No staff assistance was provided with eating. The dietary card indicated a divided plate with raised sides should have been provided for R106. On 8/31/16, at 8:30 a.m. dietary staff (DS)-A stated cards for each person with assistive devices were on the cart, but were not always	2 570		

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2 570	Continued From page 15 accurate. R106's current care plan dated 7/21/16, did not have weight loss as a concern and did not identify R106's tooth extractions. The care plan did not include the adaptive equipment for eating, and noted R106 was independent with eating. During an interview with the consulting dietitian on 9/1/16, at 12:20 p.m. she stated the care plan would be updated by nursing for oral surgeries. The weight of 148 pounds had not been brought to her attention. On 9/2/16, at 8:45 a.m. the care planning policy was requested but was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or desginee could review policies. Education of appropriate staff could be provided. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served.	2 965		10/12/16

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2 965	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain acceptable parameters of body weight for 2 of 3 residents (R16, R106) reviewed for weight loss. Findings include: R16 reported on 8/30/16, at 7:28 p.m. he had resided at the facility since the previous winter. R16 explained that the speech therapist would not let him eat and he was fed via a tube feeding. "I eat and drink when I get a chance. They are supposed to get me in for a swallow study. I had aspiration pneumonia and was at the hospital." R16's nutrition care plan dated 4/4/16, indicated R16 was nutritionally at risk related to cardiac disease, and was at risk for dehydration secondary to diabetes type II. Care plan goal was "weight will remain stable +/-3%." Care plan directed staff to provide diet as ordered, nothing by mouth (NPO), supplements were ordered and weights monitored as needed (PRN) per protocol. The nutrition progress note dated 4/8/16, indicated R16 was to be followed up monthly for tube feeding tolerance and weight stability. Nutrition note dated 4/14/16, indicated resident was not meeting the estimated nutrition and hydration secondary to resident discontinuing himself from the tube feeding pump during the day to smoke. Resident had agreed to change the feedings to bolus to help ease compliance of tube feeding. The Nutrition Risk Data Collection and Assessment completed 7/18/16, indicated R16 had refused a weight in July and continued	2 965	Corrected	

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2 965	Continued From page 17 on bolus tube feeding four times daily. However, it did not indicate risk and benefits had been reviewed with R16. R16's nutrition Care Area Assessment (CAA) dated 4/18/16, indicated the resident had dysphagia, was to have nothing by mouth and received tube feedings. R16's diagnoses included dysphagia oropharyngeal phase, gastrostomy, tracheostomy, hypothyroidism, anemia and diabetes type II obtained from the quarterly Minimum Data Set (MDS) dated 7/8/16. In addition the MDS indicated R16 received tube feedings, and "No or unknown" for loss of five percent (%) or more in the last month or loss of 10% or more in last six months with no weights recorded in the MDS. During document review it was revealed: -R16 had no condition or chronic disease that may result in a life expectancy of less than 6 months -Was not on a planned weight loss program -Had a 18 pounds (lbs) weight loss between the closest weight to survey and most recent re-admission weight which was a 9.7% weight loss. -Vital Signs--Individual Resident Flowsheet revealed no weights had been obtained or documented on admit 11/18/16, through 4/1/16. -4/2/16, weight was 199.8 lbs -4/7/16, weight was 202.0 lbs -4/11/16, weight was 202.6 lbs -May 2016 no weights obtained -June 2016 no weights obtained -7/7/16, refused weight -8/30/16, weight was 185.6 lbs obtained after surveyor requested R16 to be weighted.	2 965		

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2 965	Continued From page 18 On 8/30/16, at 11:40 a.m. the consultant registered dietitian (RD) acknowledged it had been a struggle getting residents when asked about the multiple missing weights in the medical record. The RD stated she was doing assessments without weights and had to document weights were not obtained or refused. The RD stated she started working at the facility in 4/16. The RD indicated she had sent e-mails about the weight issues weekly to corporate, including the executive director (ED) and director of nursing on about the issue. The RD further stated "I need other departments to jump on board so we can get this issue resolved." The RD acknowledged nutritional assessments and MDS's were not accurate because weights were unavailable. On 8/30/16, at 11:44 a.m. licensed practical nurse (LPN)-C stated she had two months when obtaining the weights had been successful, however it had become a problem again and they would try again in September. On 9/1/16, at 2:33 p.m. the RD stated she did not know why R16 had a gastrostomy tube. When asked why a swallowing study had not been completed, the RD replied, "I believe he went to the 'trach people' and was told his trach would never be removed when [R16] was in the transitional care unit [TCU]." When asked if R16's weight was supposed to be monitored monthly, the RD stated "I would like to keep up with it." The RD acknowledged a hindrance to monitoring residents was learning the new role and balancing her time between two facilities. The RD stated she had probably noticed the missing weights at the time and went to work on another resident/chart and never got back to it. The RD	2 965		

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2 965	Continued From page 19 stated the resident "fell through the cracks." When asked if R16 had sustained a weight loss RD stated she should have been notified of the weight loss between the 4/11/16, and 8/30/16, weights. The RD stated she would have expected the nurse documenting the weight to have provider her with updates. The RD further stated R16 was at a high risk for malnutrition and she would have re-evaluated the current interventions since she had identified the 9.7% weight loss. On 9/1/16, at 4:10 p.m. the nurse practitioner (NP) stated she would have expected the RD to monitor R16's weights closely due to R16's high risk for nutritional issues because of the diabetes and refusing tube feeding. The NP stated she had received a call from one of the nurses at the facility indicating R16's tube feeding type had run out and the facility needed an order for a different brand. The NP stated prior to giving the recent tube feeding order she had requested R16 to be seen by RD but was told the RD had not seen R16 yet. The facility Enteral Tube Feeding policy dated 7/15, indicated the dietitian was to review/evaluate changes in conditions such as weight loss, discuss intolerance and/or concerns with nursing staff such as weight loss, recommend changes to the physician as needed to improve/stabilize resident nutritional status, monitor the interventions and effectiveness and to educate the resident and family as needed during each assessment and reassessment. R106's quarterly MDS dated 7/16/16, revealed diagnoses including anemia and a mood disorder. R106 needed set up at meals, was independent with eating, and had no weight loss issues.	2 965		

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2 965	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, cereal in a bowl and a regular plate. No staff assistance was provided with eating. The dietary card indicated a divided plate with raised sides should be provided for R106. On 8/31/16, at 8:30 a.m. dietary staff (DS)-A	2 965		

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2 965	Continued From page 21 stated cards for each person with assistive devices are on the cart, but were not always accurate. On 9/1/16, at 12:20 p.m. the RD stated obtaining weights had been on ongoing issue. She had asked for weights to complete nutrition assessments and not received them. Regarding the weight for R106, the assessment did not address weight loss. If it had, she would have asked for a reweigh and assured the loss was accurate. She stated that meal observations were not a normal part of the assessment. Adaptive equipment would be recommended by therapy if a resident attended. The weight loss and weight of 148 lbs. had not been brought to her attention. The RD stated the oral surgeries would have been addressed in the care plan by nursing. R106's current care plan dated 7/21/16, did not have weight loss as a concern and did not identify R106's tooth extractions. The care plan did not include the adaptive equipment for eating, and noted R106 was independent with eating. The facility's 7/15, Weight Loss policy indicated when significant weight loss was identified the interdisciplinary team would determine interventions based on the resident's individual cause of weight loss and these interventions were to be added to the resident's care plan. SUGGESTED METHOD OF CORRECTION: The registered dietitian could review residents who experienced or had potential for weight loss. Education of appropriate staff could be provided. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one	2 965		

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2 965	Continued From page 22 (21) days.	2 965		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement a policy and procedure related to pneumococcal conjugate vaccine	21390	corrected	10/12/16

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21390	Continued From page 23 (PCV13) for 1 of 5 residents (R64) whose vaccination histories were reviewed. Findings include: The Center for Disease Control and Prevention identified "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. R64's Immunization record, dated 7/28/09 indicated the 79 year old resident received the Pneumovax in 2007, there was no evidence he had been offered the PCV13 vaccine since his admission to the facility on 7/28/2007. On 9/02/2016, at 8:00 AM the director of nursing (DON) was interviewed and stated the new guidelines for updating pneumococcal vaccines had been implemented partially in the facility, and agreed R64 had not received an updated vaccine. The facility policy dated 7/16 indicated that "All adults 65 years of age or older receive a dose of PCV13 followed by a dose of pneumococcal polysaccharide vaccine [PPSV23] at least 1 year later." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or infection control nurse could review immunization status for all residents to determine whether vaccination should be offered. Residents who decline vaccination could be educated as to the risks and benefits, and if the resident continues to decline, document in the	21390		

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21390	Continued From page 24 resident's immunization record. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure completion of tuberculosis testing for 4 of 5 residents (R78, R96, R161, R172) and 4 of 5 employees (E5, E6, E8, E9).	21426	Corrected	10/12/16

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21426	Continued From page 25 Findings include: R78 admitted to the facility on 3/5/11. A tuberculin skin test (TST) was administered on 3/8/11 but was no read. A second TST was administered on 3/17/11 and read on 3/20/1. There was no evidence of a symptom screen prior to administering the TST. R96 admitted to the facility on 6/28/16. A TST was administered on 6/28/16 and read on 7/1/16. There was no evidence a second step TST was administered nor was a symptom screed prior to administration of the first TST. R161 admitted to the facility on 5/25/16. A symptom screen was completed on 5/26/16. A TST was administered on 5/26/16 and read on 5/29/16. There was no evidence of a second TST administration. R172 admitted to the facility on 7/21/16. There was no evidence of a first or second step TST administration, nor was there evidence of a symptom screen. During an interview on 9/2/16, at 7:27 a.m. the director of nursing (DON) stated the human resources department was responsible for monitoring of the employee TST's. She stated each employee should have had a symptom screen completed and a two step TST. The DON further stated nursing was responsible for the resident TST's and each resident should have had a symptom screen and a two step TST. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or infection control nurse could review TB policies. The infection control	21426		

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21426	Continued From page 26 nurse could ensure all staff are appropriately screened according to standards of practice. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor target	21540	corrected	10/12/16

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21540	Continued From page 27 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: R37 was observed on 8/31/16, at 8:46 a.m. at the nursing station talking on the phone. The resident was appropriate and calm. After the conversation, R37 returned to her room and shut the door. From 9:00 a.m. to 11:00 a.m. was lying in bed. The care plan for R37's mood and behavior symptoms assessment dated 11/10/15, indicated the resident had a potential for side effects from psychotropic drug use. The care plan identified R37 used Trazodone for depression and Seroquel for traumatic brain injury with cognitive decline. The care plan directed staff to monitor for hypotension (sudden drop in blood pressure with rising, common with psychotropic medication use), behavior and cognitive impairment deterioration. A psychotropic drug use Care Area Assessment (CAA) for R37 dated 11/19/15, indicated the resident used Seroquel and Trazodone. In addition, the CAA indicated R37 had potential for adverse effects from medications and directed to review the care plan for interventions. R37's physician orders dated 6/6/16, revealed orders for the antipsychotic, quetiapine fumarate (for Seroquel) 25 mg twice daily for dementia with behavioral disturbances and the antidepressant commonly used to promote sleep,Trazodone 150 mg at bedtime for depression. R37's diagnoses included dementia, traumatic	21540		

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21540	Continued From page 28 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. On 8/31/16, at 12:23 p.m. LPN-A stated R37 had the behavior of cursing out but did not strike out at others. At times she cursed at staff, but when re-approached an hour or so later she would be pleasant. LPN-A further stated R37 had a good support system and would use the phone to talk with family. She did not think R37 was depressed. On 9/1/16, at 6:45 a.m. LPN-B stated R37 had never had any physical behaviors of hitting, kicking or harming self or other that she was aware of. LPN-B indicated the resident was very verbally aggressive toward staff, depending if they had established a rapport with her. On 9/1/16, at 9:31 a.m. LPN-C stated R37's chart did not have a Seroquel consent for medication use and R37 had no behavior monitoring in place. In addition, LPN-C stated no orthostatic blood pressures were obtained in the last three months further stating "They are supposed to be done at least once a month for psychotropic medication use." On 9/1/16, at 10:06 a.m. licensed social worker (LSW)-A acknowledged behavior monitoring had not been completed for R37 for the last 90 days. LSW-A stated the staff had documented behavior on only one occasion. LSW-A acknowledged no one had been tracking the documentation to ensure behavior monitoring was being completed. LSW-A further stated the social services department had just filled the positions which would help closely audit and review documentation of behavior moving forward.	21540		

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21540	Continued From page 29 On 9/1/16, at 4:09 p.m. R37's nurse practitioner (NP) stated she would have expected the staff to complete behavior tracking and trending as R37 had occasional psychosis. The NP had discussed with R37 that medications were for the resident's comfort and well being. The NP further stated she would have expected the staff to monitor orthostatic blood pressure for a resident on antipsychotic medication per facility protocol because of the potential for orthostatic hypotension with Seroquel and Trazodone use. On 9/1/16, at 4:24 p.m. the director of nursing stated she also would have expected the behaviors to be monitored and orthostatic blood pressures to be checked monthly. SUGGESTED METHOD OF CORRECTION: The director of nursing or desginee could review records of residents prescribed psychotropic medications for appropriate monitoring. Education of appropriate staff could be provided. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21670	MN Rule 4658.1405 A.B.C.D. Resident Units The following items must be provided for each resident: A. A bed of proper size and height for the convenience of the resident, a clean, comfortable mattress, and clean bedding, appropriate for the weather and resident's comfort, that are in good condition. Each bed must have a clean bedspread. A moisture-proof mattress or	21670		10/12/16

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21670	Continued From page 30 mattress cover must be provided for all residents confined to bed and for other beds as necessary. Rollaway type beds, cots, or folding beds must not be used. B. A chair or place for the resident to sit other than the bed. C. A place adjacent or near the bed to store personal possessions, such as a bedside table with a drawer. D. Clean bath linens provided daily or more often as needed. E. A bed light conveniently located and of an intensity to meet the needs of the resident while in bed or in an adjacent chair This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure clean and sanitary bed linens were provided as needed for 1 of 2 resident (R90) reviewed for urinary incontinence. Findings include: On 8/29/16, at 10:39 a.m. during resident interview and room observation the bed was observed not made and the bottom fitted sheet with multiple smears of brown matter. The room was noted to have a strong smell even though there were two fans running at the time. On 8/30/16, at 12:10 p.m. during a random room observation the bed was observed un-made and both the fitted sheet and top sheet had smears of brown matter and in addition the room had a malodorous smell.	21670	corrected	

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21670	Continued From page 31 On 8/30/16, at 7:09 a.m. resident was observed in room watching television. When approached and asked about what assistance staff provided, resident stated he was independent with all his cares however staff both nursing and house keeping assisted him with cleaning the room and changing the bedding's. The top sheet was observed with multiple smears of brown matter. On 8/31/16, at 12:13 p.m. licensed practical nurse (LPN)-A stated she would expect the staff to assist any resident who were independent with making sure soiled linen was changed on the bed and getting gown among other things. She indicated there were residents who were independent but still needed staff assistance with some things. On 8/31/16, at 12:29 p.m. resident was observed out of the room the top sheet had multiple smear of yellow brown smears. At 12:30 p.m. nursing assistant (NA)-C stated he was supposed to change the linen for resident however had to wait for resident to be out of his room for him to come and do it. He verified resident sheet was soiled and removed it from the room. He stated he had been to the room and changed the linen he thought on the last two days before the end of the shift. On 9/1/16, at 9:41 a.m. registered nurse (RN)-B stated staff "should change them in the morning. Resident spends a lot of time in the room and is cooperative for staff to approach and change the linen. Staff have to explain as resident is set in his ways." On 9/1/16, at 4:25 p.m. the director of nursing stated she would expect the nursing assistant to assist a resident with changing the soiled linen.	21670		

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21670	Continued From page 32 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.m. the linen policy was requested but was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or desginee could review policies. Education of appropriate staff could be provided. Room observations/audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21670		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the	21980		10/12/16

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21980	Continued From page 33	21980		

information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:

(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or

(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).

(b) A person not required to report under the provisions of this section may voluntarily report as described above.

(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.

(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.

(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this

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21980	Continued From page 34 information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of abuse to the designated State agency (SA) in accordance with facility policy for 4 of 6 residents (R29, R75, R19, R10) who alleged mistreatment by facility staff. Findings include: R29's admission Minimum Data Set (MDS) dated 6/24/16, indicated she was cognitively intact and required extensive assistance with activities of daily living. R29's care plan dated 6/16 identified her as a vulnerable adult and at risk for abuse/neglect. The care plan directed staff to watch for signs and symptoms of abuse and neglect and investigate concerns per policy. On 8/29/16, at 10:10 a.m. R96 reported her roommate (R29) had been abused by a staff member approximately one week prior, when a staff member made her wait for her medications and laughed at her. On 8/30/16, at 6:31 p.m. R29 stated nursing assistant (NA)-B treated her unprofessionally, and spoke to her in "an abusive manner." She stated NA-B came at her in a loud tone and embarrassed her in front of everyone in the dining room. R29 stated she cried for five hours following the incident and felt he was intentionally taunting her. R29 stated NA-B was still working on her unit and she preferred he not give her medications, but there was no other option. She	21980	corrected	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEXAS TERRACE CARE CENTER	7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426

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21980	Continued From page 35 stated she had filed a complaint and gave it to one of the staff. A review of a Resident Concern Report dated 8/17/16, indicated R29 had filled out a report regarding NA-B who "repeatedly" yelled at her. In the concern form R29 had indicated NA-B was "mentally abusive" to her and stated she had enough problems without him yelling at her. The report indicated the incident was regarding a request for pain medications. The report further indicated after speaking with NA-B, the executive director (ED) felt he could "un-substantiate abuse/neglect." The report indicated R29 was "trying to manipulate pain meds [medications] as is typical of her history." During an interview on 8/13/16, at 11:29 a.m. the ED stated he was aware of the allegation of abuse by R29. He stated he was able to speak to the nurses on duty the same day the incident occurred. He further stated he knew NA-B very well and had received no concerns. He stated when asked what happened, NA-B had stated he had gotten "firm with her [R29]." The administrator stated, because of R29's past, "I felt we were able to un-substantiate the mental abuse." During a subsequent interview at 1:58 p.m. The ED stated the incident should have been reported to the SA. R75's quarterly MDS dated 8/9/16, identified R75 had moderately impaired cognition. The MDS also identified R75 required extensive assistance of two staff for dressing, repositioning, toileting and bed mobility. R75's careplan dated 7/5/16, identified R75 as a vulnerable adult with cognitive impairment, identified his cognition status as easily distracted,	21980		

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21980	Continued From page 36	21980		

and further indicated R75 was able to voice his own concerns. The care plan further directed staff to report and investigate all concerns per policy.

A resident concern report dated 7/5/16, indicated R75 had filed a concern regarding NA-F and another NA who had worked on 7/4/16. R75 stated staff had been taking 2-3 hours to respond to his request to use the bathroom. It was also reported that NA-F and another aide who worked 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.

An interview with the ED on 9/2/16, at 8:36 a.m. revealed R75's concern had not been reported to the SA. The ED stated he had investigated the concern immediately and found the concern to be "un-substantiated" therefore, did not report the concern to the SA. The ED went on to say that NA-F did not provide cares to other residents until he had spoken with her on 7/6/16, and since the concern was not substantiated, NA-F had been allowed to continue working.

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21980	Continued From page 37 R19's Resident Concern Report dated 8/8/16, indicated "[R19's] daughter wants to make a complaint about her mom being treated rough by a male NA last night 8.7.16. Aide who took care of [R19] was rough when helping with changing her under garment. Daughter stated she had concerns about mom having a male NA and wanted resident to have a female NA at all times...." The investigative report indicated on 8/8/16, a telephone call was made to the male NA who indicated he had been to the resident's room at 6:07 p.m. to ask if he could change her and the resident had asked him to "come back at 0400" (4:00 a.m.). NA then re-oriented resident to the time of day and asked resident if he could change the brief and R19 then allowed the cares. During the cares, R19 never asked him to stop or get a female NA and never stated he was hurting her or being or being rough with pericare. In the investigation, R19 had been interviewed on 8/8/16, and was asked if she felt she had received good cares over the last 24 hours "Yes," if she felt comfortable with everyone who gave her cares "Yes,"and if she felt anyone had hurt her over the last 24 hours and resident stated "No." However, during the interview R19 reported a desire to move to second floor and stated she preferred a female NA. On 9/1/16, at 11:26 a.m. ED and DON were interviewed and reviewed regarding the concern report for R19. The ED stated the concerns was not reported to the SA, as the investigation was done the same day the facility was made aware, and that the NA in question had been able to describe in depth the cares provided. ED stated R19 was confused and unable to give specifics and roommate and others had been interviewed and offered no concerns. ED further stated, "We	21980		

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21980	Continued From page 38 should have reported it immediately instead, but we took our 24 hours to investigate." R19's annual MDS dated 6/17/16, indicated R19 had moderately impaired cognition and did not have any psychosis, delusions, or hallucinations. In addition, R19's diagnoses included dementia and anxiety. The cognitive assessment care plan dated 6/16, identified R19 had periods of altered perception, was a vulnerable adult, was 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." In the investigation dated 6/2/16, indicated R158 had been interviewed at 4:15 p.m. and had reported "a week ago or so in the dining room [NA-E] pushed down on [R10's] shoulders when she stood up from her chair and god dammit I told you to sit down." The Resolution and disposition of the concern sheet indicated both the ED and DON agreed R158's accusation was immediately not substantiated for abuse/neglect per staff, resident and family members, and no one had ever witnessed NA-E or any other staff treat R10 inappropriately. The report further indicated R10 was at time agitated, was a fall risk and impulsive and staff did try to stop her from getting up out of the chair unsafely but not in a malicious way and NA-E denied swearing at any resident. R10's admission MDS dated 5/19/16, indicated	21980		

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21980	Continued From page 39 R10 had severely impaired cognition with dementia, and no wandering behavior was displayed. On 9/1/16, at 11:27 a.m. the ED stated R10 displayed extreme behaviors, accusing staff of stealing his medications, causing a stir and was a unreliable reporter. The ED indicated staff on the shift had been called in and interviewed. R10 was identified as very impulsive and at high risk for falling. The ED indicated NA-E was behind nursing station, and resident was behind the table when R10 stood, NA-E rushed over and said "It's okay. what do you need? Do you need the bathroom?" When asked if the allegation should have been reported to the SA the ED stated "We should have reported it first and but we were able to un-substantiate abuse in the first 24 hours." The facility's 7/15, Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including injuries of unknown source, and Misappropriation of Resident Property policy directed "All allegations that meet the definition of abuse and substantiated violations will be reported to state agencies and to all other agencies including the local law enforcement, elder abuse agencies, and Adult Protective Services, as required. The center takes all necessary corrective actions depending on the result of the investigation. The center requires centers to report these alleged violations to the executive director and DON/designee immediately. 'Immediately' means as soon as possible, but not to exceed 24 hours after discovery of incident, in the absence of a shorter state time frame requirement...Neglect: Neglect is failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. This presumes that instances of abuse/neglect of all residents, even	21980		

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21980	Continued From page 40 those in a coma, cause physical harm, pain, or mental anguish...Mental/Emotional abuse: Includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation...Protection 1. Provide for the immediate safety of the resident upon identification of potential abuse, neglect, mistreatment, injuries of unknown source, and/or misappropriation of property. Require identified non-employee immediately leave the center. Suspend identified employee (s) immediately pending outcome of the investigation...." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing and or licensed social workers (LSWs) could ensure staff are trained to immediately report to the SA. Re-training could be provided. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21980		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency.	22000		10/12/16

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22000	Continued From page 41 (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review, the	22000	corrected	

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22000	Continued From page 42 facility failed to operationalize their facility policy regarding investigation and immediate reporting to the designated State agency (SA) for 4 of 6 residents (R29, R75, R19, R10) who alleged mistreatment by staff. These practices had the potential to affect all 101 residents in the facility. Findings include: The facility's 7/15, Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including injuries of unknown source, and Misappropriation of Resident Property policy directed "All allegations that meet the definition of abuse and substantiated violations will be reported to state agencies and to all other agencies including the local law enforcement, elder abuse agencies, and Adult Protective Services, as required. The center takes all necessary corrective actions depending on the result of the investigation. The center requires centers to report these alleged violations to the executive director and DON/designee immediately. 'Immediately' means as soon as possible, but not to exceed 24 hours after discovery of incident, in the absence of a shorter state time frame requirement...Neglect: Neglect is failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. This presumes that instances of abuse/neglect of all residents, even those in a coma, cause physical harm, pain, or mental anguish...Mental/Emotional abuse: Includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation...Protection 1. Provide for the immediate safety of the resident upon identification of potential abuse, neglect, mistreatment, injuries of unknown source, and/or misappropriation of property. Require identified non-employee immediately leave the center.	22000		

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22000	Continued From page 43 Suspend identified employee (s) immediately pending outcome of the investigation...." Findings include: R29's admission Minimum Data Set (MDS) dated 6/24/16, indicated she was cognitively intact and required extensive assistance with activities of daily living. R29's care plan dated 6/16 identified her as a vulnerable adult and at risk for abuse/neglect. The care plan directed staff to watch for signs and symptoms of abuse and neglect and investigate concerns per policy. On 8/29/16, at 10:10 a.m. R96 reported her roommate (R29) had been abused by a staff member approximately one week prior, when a staff member made her wait for her medications and laughed at her. On 8/30/16, at 6:31 p.m. R29 stated nursing assistant (NA)-B treated her unprofessionally, and spoke to her in "an abusive manner." She stated NA-B came at her in a loud tone and embarrassed her in front of everyone in the dining room. R29 stated she cried for five hours following the incident and felt he was intentionally taunting her. R29 stated NA-B was still working on her unit and she preferred he not give her medications, but there was no other option. She stated she had filed a complaint and gave it to one of the staff. A review of a Resident Concern Report dated 8/17/16, indicated R29 had filled out a report regarding NA-B who "repeatedly" yelled at her. In the concern form R29 had indicated NA-B was "mentally abusive" to her and stated she had enough problems without him yelling at her. The report indicated the incident was regarding a	22000		

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22000	Continued From page 44	22000		

request for pain medications. The report further indicated after speaking with NA-B, the executive director (ED) felt he could "un-substantiate abuse/neglect." The report indicated R29 was "trying to manipulate pain meds [medications] as is typical of her history."

During an interview on 8/13/16, at 11:29 a.m. the ED stated he was aware of the allegation of abuse by R29. He stated he was able to speak to the nurses on duty the same day the incident occurred. He further stated he knew NA-B very well and had received no concerns. He stated when asked what happened, NA-B had stated he had gotten "firm with her [R29]." The administrator stated, because of R29's past, "I felt we were able to un-substantiate the mental abuse." During a subsequent interview at 1:58 p.m. The ED stated the incident should have been reported to the SA.

R75's quarterly MDS dated 8/9/16, identified R75 had moderately impaired cognition. The MDS also identified R75 required extensive assistance of two staff for dressing, repositioning, toileting and bed mobility.

R75's careplan dated 7/5/16, identified R75 as a vulnerable adult with cognitive impairment, identified his cognition status as easily distracted, and further indicated R75 was able to voice his own concerns. The care plan further directed staff to report and investigate all concerns per policy.

A resident concern report dated 7/5/16, indicated R75 had filed a concern regarding NA-F and another NA who had worked on 7/4/16. R75 stated staff had been taking 2-3 hours to respond to his request to use the bathroom. It was also reported that NA-F and another aide who worked

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22000	Continued From page 45	22000		

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.

An interview with the ED on 9/2/16, at 8:36 a.m. revealed R75's concern had not been reported to the SA. The ED stated he had investigated the concern immediately and found the concern to be "un-substantiated" therefore, did not report the concern to the SA. The ED went on to say that NA-F did not provide cares to other residents until he had spoken with her on 7/6/16, and since the concern was not substantiated, NA-F had been allowed to continue working.

R19's Resident Concern Report dated 8/8/16, indicated "[R19's] daughter wants to make a complaint about her mom being treated rough by a male NA last night 8.7.16. Aide who took care of [R19] was rough when helping with changing her under garment. Daughter stated she had concerns about mom having a male NA and wanted resident to have a female NA at all times...." The investigative report indicated on 8/8/16, a telephone call was made to the male NA

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22000	Continued From page 46	22000		

who indicated he had been to the resident's room at 6:07 p.m. to ask if he could change her and the resident had asked him to "come back at 0400" (4:00 a.m.). NA then re-oriented resident to the time of day and asked resident if he could change the brief and R19 then allowed the cares. During the cares, R19 never asked him to stop or get a female NA and never stated he was hurting her or being or being rough with pericare.

In the investigation, R19 had been interviewed on 8/8/16, and was asked if she felt she had received good cares over the last 24 hours "Yes," if she felt comfortable with everyone who gave her cares "Yes,"and if she felt anyone had hurt her over the last 24 hours and resident stated "No." However, during the interview R19 reported a desire to move to second floor and stated she preferred a female NA.

On 9/1/16, at 11:26 a.m. ED and DON were interviewed and reviewed regarding the concern report for R19. The ED stated the concerns was not reported to the SA, as the investigation was done the same day the facility was made aware, and that the NA in question had been able to describe in depth the cares provided. ED stated R19 was confused and unable to give specifics and roommate and others had been interviewed and offered no concerns. ED further stated, "We should have reported it immediately instead, but we took our 24 hours to investigate."

R19's annual MDS dated 6/17/16, indicated R19 had moderately impaired cognition and did not have any psychosis, delusions, or hallucinations. In addition, R19's diagnoses included dementia and anxiety. The cognitive assessment care plan dated 6/16, identified R19 had periods of altered perception, was a vulnerable adult, was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00144	A. BUILDING: _____ 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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
22000	Continued From page 47 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." In the investigation dated 6/2/16, indicated R158 had been interviewed at 4:15 p.m. and had reported "a week ago or so in the dining room [NA-E] pushed down on [R10's] shoulders when she stood up from her chair and god dammit I told you to sit down." The Resolution and disposition of the concern sheet indicated both the ED and DON agreed R158's accusation was immediately not substantiated for abuse/neglect per staff, resident and family members, and no one had ever witnessed NA-E or any other staff treat R10 inappropriately. The report further indicated R10 was at time agitated, was a fall risk and impulsive and staff did try to stop her from getting up out of the chair unsafely but not in a malicious way and NA-E denied swearing at any resident. R10's admission MDS dated 5/19/16, indicated R10 had severely impaired cognition with dementia, and no wandering behavior was displayed. On 9/1/16, at 11:27 a.m. the ED stated R10 displayed extreme behaviors, accusing staff of stealing his medications, causing a stir and was a unreliable reporter. The ED indicated staff on the shift had been called in and interviewed. R10 was identified as very impulsive and at high risk for	22000		

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22000	Continued From page 48 falling. The ED indicated NA-E was behind nursing station, and resident was behind the table when R10 stood, NA-E rushed over and said "It's okay. what do you need? Do you need the bathroom?" When asked if the allegation should have been reported to the SA the ED stated "We should have reported it first and but we were able to un-substantiate abuse in the first 24 hours." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing and or licensed social workers (LSWs) could ensure staff are trained to immediately report to the SA. Re-training could be provided. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	22000		