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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: Z6W8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00164

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/19/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **250** (L18)
13.Total Certified Beds **250** (L17)

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

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
X 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room
* Code: **A5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	250			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date:
Eva Loch, Unit Supervisor — 10/23/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Douglas Larson, Enforcement Specialist — 10/23/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/16/2018
(L33)

DETERMINATION APPROVAL

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

Documentation supporting your request for a waiver of the following life safety code (LSC) deficiency:

K - 0521 - HVAC

The facility's request has been forwarded to the CMS Region V Office for their review and determination.

Approval of the waiver has been recommended.

Electronically delivered

CMS Certification Number (CCN): 245242

October 23, 2018

Administrator
Augustana Health Care Center Of Minneapolis
1007 East 14th Street
Minneapolis, MN 55404

Dear Administrator:

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 October 1, 2018 the above facility is certified for:

250 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 250 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K0521.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for this deficiency or renew your request for waiver in order to continue your participation in the Medicare and Medicaid Program.

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

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

Please contact me if you have any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 23, 2018

Administrator
Augustana Health Care Center Of Minneapolis
1007 East 14th Street
Minneapolis, MN 55404

RE: Project Number S5242028

Dear Administrator:

On September 6, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 23, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 19, 2018, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 23, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 1, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 23, 2018, effective October 1, 2018 and therefore remedies outlined in our letter to you dated September 6, 2018, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under K0521 at the time of the August 23, 2018 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: Z6W8

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(L3) **AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS**
(L4) **1007 EAST 14TH STREET**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/23/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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To (b) :

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13.Total Certified Beds **250** (L17)

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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
	250			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date:
Thomas O'Brien, HFE NE II — 09/17/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Douglas Larson, Enforcement Specialist — 10/15/2018 (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
01/01/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

Documentation supporting your request for a waiver of the following life safety code (LSC) deficiency:

K - 0521 - HVAC

The facility's request has been forwarded to the CMS Region V Office for their review and determination.

Approval of the waiver has been recommended.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 6, 2018

Augustana Health Care Center Of Minneapolis
Attn: Administrator
1007 East 14th Street
Minneapolis, MN 55404

RE: Project Number S5242028

Dear Administrator:

On August 23, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 2, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 2, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by November 23, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on

the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 23, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145

St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245242	A. BUILDING _____ B. WING _____	08/23/2018

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

(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 On 8/20/18-8/23/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and determine safety for self-administration of medications (SAM) for 1 of 1 resident (R215) reviewed for medication administration. Findings include:	F 554	Augustana Health Care Center of Minneapolis' plan of correction is a written credible assertion of substantial compliance with the Federal and State requirements of Nursing Facilities and/or skilled nursing facilities participating in the Federal Medicare or State Medical Assistance programs. Please note the	10/1/18

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

Electronically Signed | 09/13/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245242	A. BUILDING _____ B. WING _____	08/23/2018

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

(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 554	Continued From page 1 R215 face sheet dated 8/23/18, indicated current diagnoses vascular dementia, convulsions and hemiplegia affecting left side. R215's Brief Interview for Mental Status assessment dated 5/5/18, indicated R215 had severe cognitive impairment. R215's care plan dated 8/10/18, indicated licensed/ trained staff may leave R215's individual dose of Tylenol at bedside. In addition, the care plan also indicated licensed/ trained staff to administer all medications. R215's current physician orders dated 8/23/18, indicated an order for Tylenol was to be left at bedside. R215's SAM observation dated 7/29/18, lacked evidence of summary of assessment and conclusion of findings. On 8/22/18, at 7:21 a.m. the licensed practical nurse (LPN)-B was administering R215's medications. LPN- B prepared R215's medications and then placed into a medication cup; included approximately 10 tablets of medication. LPN-B walked to R215 proceeded to hand R215 the medication cup in the community television area. R215 placed the medication cup next to himself on the windowsill. LPN-B stated to surveyor "he usually takes his meds [medications] on his own," LPN-B proceeded to walk away with her back toward R215 and left the medications. When asked, LPN-B verified R215 did not have a SAM order for all of his medications only for his Tylenol. R215 requested LPN-B administer a second Tylenol and his supplement drink. At this time, R215 remained with four pills in the	F 554	nothing set forth in this document is to be or should be construed to be an admission by Augustana Health Care Center of Minneapolis, or the validity or accuracy of any of the deficiencies cited by the Minnesota Department of Health relative to the survey, certification, and enforcement effort at issue. Further please note that any and all documents transmitted or otherwise provided by Augustana Health Care Center of Minneapolis in relation to the Plan of Correction, as well as any and all other communications in writing or otherwise by or on behalf of Augustana Health Care Center of Minneapolis, at law and/or in equity, all of which are not waived and all of which are reserved and retained by, for and on behalf of Augustana Health Care Center of Minneapolis F554 It is the policy of Augustana Health Care Center to assess and determine safety for self-administration of medications for all residents who wish to self administer. Corrective Action Identified LPN was individually re-educated to facility policy and protocol for self administration of Medications 9-13-18 Self -administration comprehensive assessment was completed on identified resident, and care plan was updated to reflect self administration status. 9-12-18 Identification of Other Residents Facility wide audit was completed on all residents who self-administer medications, care plans were updated to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245242	A. BUILDING _____ B. WING _____	08/23/2018

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

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F 554	Continued From page 2 medication cup sitting on the windowsill and LPN-B left the area then returned a few minutes later. Upon return, LPN-B remained with R215 and watched R215 swallow the last four pills. On 8/22/18, at 11:12 a.m. LPN-A stated that the expectation was for the facility staff administering the medication to stay with the resident until the resident has taken all of their medications. LPN-A verified R215 did not have a SAM order and care plan for all medications only for Tylenol to be left at bedside. LPN-A stated that she was aware of LPN-B leaving the medications alone with R215 and that LPN-B was educated. On 8/23/18, at 11:15 a.m. the director of nursing (DON) stated that it was her expectation that, "if a resident does not have a SAM order then you watch them take their pills to ensure they took the medication." Review of the August 2018 medication administration record indicated medication given by LPN-B on the a.m. of 8/22/18 included: aspirin (given for cardiac prevention) 81 milligrams (mg) 2 tablets orally, Cerovite Senior (given for supplement) 1 tablet orally, Dilantin Extended (given for seizures) 100 mg 4 tablets orally, hydrochlorothiazide (given for high blood pressure) 25 mg 1 tablet orally, metoprolol succinate extended release (given for high blood pressure) 50 mg 1 tablet orally, and Tylenol (given for pain management) 325 mg 1 tablet orally. The facility's Self Administration of Medications policy and procedure revised November 2016, indicated that all residents who wish to SAM will have a completed SAM observation, obtained a	F 554	reflect self-administration status. 9-15-18 Measures Put in Place All licensed staff and TMA's will be educated on facility policy and procedure for self-administration of medications. 10-1-18 Monitoring Mechanisms Random monthly compliance audits will be conducted on all units day and evening shift for the next 90 days by nursing administration on the self-administration of medications process. 9-30-18 10-31-18 11-30-18 12-31-18 Audits will be reviewed by the Quality Improvement Committee for compliance with facility policy and procedure for self-administration of medications for the next 90 days. 9-30-18 10-31-18 11-30-18 12-31-18 Responsible Person/s Clinical Managers Director of Nursing Assistant Director of Nursing Staff Development Director Quality Improvement Director	

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F 554	Continued From page 3 physician order for all SAM desired medications and the residents care plan will be reviewed routinely for any needed changes.	F 554		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to comprehensively assess, develop and implement a care plan to maintain to range of motion (ROM) to right hand for 1 of 3 residents (R12) reviewed for ROM services. Findings include: R12's annual Minimum Data Set (MDS) dated 5/12/18, indicated R12 was cognitively intact and had functional limitation in range of motion	F 688	F688 It is the policy of the Augustana Health Care Center to ensure that a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion, unless a reduction in mobility is demonstrably unavoidable Corrective Action identified resident was assessed during the annual survey on 8-23-18 which	10/1/18

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F 688	Continued From page 4 impairment on one side to upper and lower extremities. R12's activity of daily living functional status/ rehabilitation potential care area assessment dated 5/12/18, indicated R12 needed assistance with activities of daily living related to schizophrenia, hemiplegia, cerebral palsy and cognitive impairment, however, lacked evidence of assessment related to R12's right hand ROM impairment. R12's face sheet dated 8/23/18, indicated diagnoses including hemiplegia affecting right dominant side and cerebral palsy. R12's care plan dated 8/17/18, lacked evidence of right hand functional ROM impairment, or care and interventions to prevent decline, maintain current ROM and/or daily cares. During interview on 8/20/18, at 12:50 p.m. R12 stated that he had been unable to open the right hand for years. R12 verbalized that at times he will attempt to push a wash cloth between fingers and hand on his right side because if got sweaty. R12 also said that he sometimes will wash his right hand with soap and water to get the sweat out of it. R12 asked to open right hand and R12 was unable to move or open fingers and thumb, and his right hand remained clenched. R12 stated that the facility staff did not assist him with washing his hand and that he did not have any brace or exercises for the right hand. R12 was noted to have a sour smell in the palm of his right hand. On 8/21/18, at 2:02 p.m. R12 was observed seated in the wheelchair with his right hand clenched and no evidence of any assistive devices or rehabilitative equipment present. .	F 688	demonstrated no change in function. The care plan was updated. Resident was approached for implementation of a Occupational Therapy treatment program for management of right hand/finger deformity which may include ROM and/or orthotics this was declined as resident has done in the past. A risk to benefits was done with the resident on 9-12-18 in regards to declining treatment program. Resident will be re-approached at next quarterly care conference with program recommendation, and a comprehensive assessment will be conducted annually or per change of condition. 12-15-18 Identification of Other Residents All residents with limited range of motion/contractures were reviewed by the Interdisciplinary team on 8-29-18. All identified residents will be screened by Therapy Services and a comprehensive assessment will be implemented if indicated per screen. Therapy Services will update care plan and implement appropriate therapy programs as needed. 10-1-18 All residents who have not had an annual screen in the past 12 months will be screened before their next quarterly care conferences. 11-30-18 Measures Put in Place Education review of facility protocol for Therapy Services will be conducted with all Therapy staff to ensure staff are aware that all residents should receive annual screens for functional status. 9-15-18	

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F 688	Continued From page 5 During interview on 8/22/18, at 9:37 a.m. licensed practical nurse (LPN)-A stated that R12 was currently being seen by occupational therapy (OT) for wheel chair positioning. LPN-A verified that to her knowledge R12 was not seeing OT for his right hand. LPN-A confirmed that R12 had a diagnosis of right sided hemiplegia with a right hand contracture. LPN-A reviewed R12's record and stated that she did not see R12's right hand cares, brace or splint addressed on the care plan or any completed assessment that addressed R12's right hand. LPN-A also stated that there were no orders on the medication or treatment administration record regarding cares or interventions of R12's right hand. During interview on 8/22/19, at approximately 3:00 p.m. director of therapy (DOT) indicated that R12 was currently on OT case load for wheelchair positioning, however found no information regarding R12's right hand. During interview on 8/23/18, at 9:39 a.m. R12 stated that his right hand had been like this since he was born and that he used to be able to open it more however he wasn't worried about it currently. R12 denied any pain to his right hand. R12's history and physical dated 12/2/04, indicated that R12 had a diagnosis of cerebral palsy with congenital birth defect resulting in disability of right arm. During interview on 8/23/18, at 10:05 a.m. nursing assistant registered (NAR)-B indicated that R12 did not have a brace, splints or exercises that she was aware of for R12's right hand. NAR-B verified that there was nothing on the NAR care sheet about cares to the R12's right	F 688	Weekly Therapy Review meetings have been implemented for all long term care residents to include quarterly reviews of all residents, and to ensure all residents receive an annual screen by therapy services and appropriate programs are continued and/or implemented per plan of care. 9-12-18 Monitoring Mechanisms Random monthly audits will be conducted on all units by nursing administration for the next 90 days to ensure residents are receiving annual screen, and comprehensive assessments when indicated, and that a care plan is implemented to maintain resident's functional abilities. 9-30-18 10-31-18 11-30-18 12-31-18 Compliance audits will be reviewed by the Quality Improvement committee for the next 90 days to ensure compliance with facility policy and procedures for the provision of Therapy Services, and assessment and implementation of a care plan to maintain residents functional abilities. 9-30-18 10-31-198 11-30-18 12-31-18 Responsible Person/s Director of Therapy Services Clinical Managers Director of Nursing Assistant Director of Nursing	

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F 688	Continued From page 6 hand. The care plan dated 3/17/10, indicated R12 refused any right hand interventions in relation to his contracture furthermore it was indicated that the doctor and family were aware of R12's refusals of intervention and in agreement with his refusal. During interview on 8/23/18, at 11:52 a.m. director of nursing (DON) stated that R12 was not being seen in therapy for his right hand however it was offered to R12 today and he had refused. DON confirmed that the last documented care plan that indicated right hand impairment was dated February 2011. DON also verified that the last found therapy program recommended a splint on at night when sleeping off during the day was dated 7/8/09. DON stated R12's right hand impairment concern "likely fell off the care plan when we transitioned from paper to electronic back in 2014." During interview on 8/23/18, at 2:06 p.m. the occupation therapist (OT)-A stated that she had just completed an evaluation of R12's right hand ROM and indicated that compared to R12's 2009 measurements R12's ROM remained unchanged at 90 degrees of flexion. OT-A indicated that R12 could benefit from an active ROM program and a splint however R12 declined at the time of evaluation. DOT (who was also present during this interview) also indicated that the facility did not routinely assess residents unless the resident was on an active restorative program. A policy regarding process for assessments of contractures was requested but not provided.	F 688	Quality Improvement Director	

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F 698	Continued From page 7	F 698		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the dialysis access site was monitored and assessed upon return from the dialysis treatment, for 1 of 2 residents (R627) reviewed for dialysis. Findings include: R627's admission Minimum Data Set (MDS) with assessment target date 3/20/18, identified R627 had intact cognition, and had diagnosis of renal insufficiency, renal failure or end stage renal disease (ESRD). The Care Area Assessment (CAA) dated 5/31/18 also indicated R627 received dialysis, received a renal diet, and was on fluid restrictions. However the CAA lacked documentation of R627's fistula (intravenous access for dialysis) and did not identify any special cares related to dialysis access site. R627's physician's orders dated 8/12/18, directed staff to remove dressing from dialysis site on the shift after they return from dialysis, at bedtime. R627's care plan dated 3/22/18, indicated resident was on hemodialysis due ESRD, and approaches included: remove dressing from	F 698	F698 It is the policy of Augustana Health Care Center to ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Corrective Action Identified resident's dialysis orders were immediately reviewed and updated, care plan was updated per dialysis standard of care. 8-22-18 Identified licensed staff person was re-educated on professional standards of dialysis care. 8-31-18 Identification of Other Residents: All residents receiving dialysis services were audited for compliance with professional standards of practice for dialysis care and following facility policy and procedures for dialysis services. 9-14-18 Measures Put in Place All licensed staff will be educated on professional standards of practice for	10/1/18

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F 698	Continued From page 8 dialysis site on the shift after they return from dialysis, (dated 5/31/18); check shunt for bruit every shift (dated 3/22/18); and notify interdisciplinary team, physician and dialysis unit if resident refused dialysis or was non-compliant with protocols. The care plan also directed staff to monitor vital signs every shift after dialysis; no blood pressure reading in left arm due to shunt; monitor fluid access; monitor access site for signs and symptoms of infection; and monitor for bleeding or hematoma at fistula or vascular access site. If bleeding occurred at shunt site, apply direct pressure for 20 minutes, and call the physician if bleeding didn't stop. On 8/22/18, at 8:49 a.m. R627 was observed laying in the bed. When asked how she was R627 stated "I don't know that yet", and indicated she did dialysis Mondays, Wednesdays and Fridays, at 2:00 p.m. R627's left arm was visible with access site covered with two dressings. R627's tray was on the bedside table, and she stated she didn't have breakfast yet. At 10:15 a.m. R627 was observed and interviewed again. R627's bed was against the wall, with left arm on the outside. Nursing assistant (NA)-C and Licensed Practical Nurse (LPN)-B entered the room. NA-C removed the breakfast tray and stated R627 was going to receive a shower. At 11:17 a.m. R627 was interviewed again and stated she has been doing dialysis for 4 years. R627's left arm had the same dressings on. R627 said the dressing on the shunt was from the Monday Dialysis (2 days ago), and she liked to keep the dressing on the shunt, to help provide a visual aid for staff when taking vital signs. R627 stated staff took blood pressure over the shunt at times, and she didn't always wake in time to prevent that from happening. R627 stated shunt	F 698	dialysis care and facility policies and procedures for dialysis services. Monitoring Mechanisms: Monthly audits of all current and new residents receiving dialysis services will be conducted for the next 90 days to ensure compliance with standards of care and facility policy for dialysis services. 9-30-18 10-31-18 11-30-18 12-31-18 Audits will be reviewed for meeting professional standards for dialysis care and services by the Quality Improvement committee for the next 90 days. 9-30-18 10-31-18 11-30-18 12-31-18 Responsible Person/s Clinical Managers Director of Nursing Quality Improvement Director	

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F 698	Continued From page 9	F 698		

site was left uncovered during the shower and the dressings (on both insertion sites) were wet. R627 also stated that didn't matter, facility staff had "no business" with taking the dressing off the shunt, and that was something dialysis unit took care off. R627 also stated dialysis staff knew about her preference to keep the shunt dressing on, dialysis staff to remove with next treatment, and they were okay with that. R627 also explained that once, long time ago the shunt site started to bleed slowly at night, and that was the second reason she wanted to keep the dressings on the shunt. NA-C walked into the room and took R627's blood pressure on the right arm.

On 8/22/18, at 11:48 a.m. NA-C was interviewed and stated, she didn't usually take care of R627, but learned today that she didn't have a shower for a long time. R627 was able to communicate today what she wanted, and didn't want the arm access site to be covered, so the dressings got wet. NA-C explained R627 said the stumps needed to be redressed by the nurse, but didn't know what the nurse planned on doing about the wet dialysis access site dressing.

On 8/22/18, at 11:57 a.m. LPN-B was interviewed and stated she didn't regularly work on this unit. LPN-B stated staff monitored access site for complications, such as bleeding, infections, redness or pain, and also monitored bruit and thrill. LPN-B looked through R627's medication and treatment administration record and stated she didn't find any special orders for access site care. LPN-B stated she was going to change the access site dressing, since she noticed during skin check after R627 received shower that the access site dressings were not covered, and got wet. At 12:11 p.m. LPN-B came to tell, that by the

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F 698	Continued From page 10	F 698		

time she got to the room, R627 took the access site dressings off herself, and refused to have access site covered. LPN-B could not remember any incidents with bleeding in the past, didn't know what supposed to happen with the shunt dressings in between dialysis, and was going to ask the nurse manager on the unit about it.

On 8/22/18, at 12:50 p.m. LPN-A (also clinical manager) was interviewed and stated all dialysis patients came with a care plan from the dialysis unit, which was integrated in the facility's care plan. After reviewing R627's record LPN-A stated there was an order for staff to remove the access site dressing at bedtime, which was important in order to monitor the site after the run, for bleeding, redness, swelling, and make sure there was no change with the access site. LPN-A also stated if resident refused, staff were supposed to clarify with shift supervisor, or call physician's for follow up. LPN-A stated staff were expected to follow physician's orders, and follow care plan. LPN-A stated there might have been a concern about how the treatment orders uploaded in the electronic system with R627's most recent readmission (from 8/12/18), and was going to check on it.

Review of treatment administration record from 8/12/18 through 8/22/18, included for dialysis care: check access site for S/Sx (signs/symptoms) of infection; check for shunt for bruit, and to remove dressing from dialysis site on the shift after they return from dialysis, all marked with "X".

On 8/23/18, at 10:12 a.m. the dialysis unit registered nurse (RN)-D was interview via telephone call. RN-D stated the nursing home

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staff was expected at a minimum to do daily access site assessments, and that was possible only if they removed the dressing. Staff were supposed to use a stethoscope to auscultate for bruit and feel with their fingers for the thrill, after taking the dressing off. RN-D also stated staff were supposed to also look at the dialysis access site and monitor for bleeding, and complications. If resident wanted to have the access site re-dressed, that was an option. RN-D never heard there was a concern with R627 not letting staff take dressing off post dialysis, and staff not being able to complete their assessment. RN-D also stated that was something they would do education for patients, no matter they lived at home or a nursing home.

On 8/23/18, at 10:39 a.m. the director of nursing (DON) was interviewed, and stated staff were expected to monitor the access site, and also check bruit and thrill were present every shift, staff would have to auscultate and feel the access site with their fingers to do so. DON stated that was "impossible" to do through the dressing, so staff needed to remove dressing after dialysis. DON reviewed R627 and verified that there was a physician's order to remove the access site dressing, and that was also care planned. DON stated staff were expected to follow physician's orders, and residents care plan. DON explained if resident didn't want the dressing to be taken off, and needed assessments completed, staff were expected to clarify further care orders with the physician. DON wasn't sure what was the disconnect between the physician's orders and treatment records, and stated that was something for the facility to clarify with their IT (information technology) department.

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F 698	Continued From page 12 The facility's Dialysis Clinical policy dated 6/28/18, indicated "1. Residents who require dialysis will receive this service consistent with professional standards of practice, the comprehensive person-centered plan of care, and the resident's goals and preferences. 2. The facility will provide ongoing assessment of the resident's condition and will monitor for complications before and after each dialysis treatment received at a certified dialysis facility."	F 698		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health 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. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, develop and implement identified psychological interventions to promote well-being and reduce irritation for 1 of 1 resident (R168) reviewed for behavioral and chemical dependency concerns. Findings include: R168's face sheet dated 8/23/18, indicated R168 was admitted to facility on 4/13/18, current	F 740	F740 It is the policy of the Augustana Health Care Center that each resident receives and the facility provides the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive plan of care. Corrective Action Identified resident's care plan and behavioral contract were reviewed and	10/1/18

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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 740	Continued From page 13 diagnoses included: cerebral infarction, moderate to severe cognitive linguistic and adjustment disorder with disturbance of conduct. R168's admission Minimum Data Set (MDS) dated 4/20/18, indicated R168 was unable to complete cognitive interview and staff interview should be conducted however, the staff interview was incomplete. R168's cognitive skills for daily decision making was left blank. R169's Brief Interview for Mental Status (BIMS) assessment dated 4/23/18, indicated R168 was cognitively intact. The Resident Mood Assessment (PHQ-9) dated 4/23/18, noted R168 had moderately severe symptoms of depression. R168's significant change MDS dated 7/21/18, revealed R168's cognitive patterns, daily decision making skills, mood and behavior were not assessed. The MDS indicated R168 did not have any behavioral symptoms, with no hallucinations or delusions present. R168's nursing home visit physician progress note dated 4/19/18, indicated R168 had a diagnosis of alcohol use disorder dated 4/19/18, and R168 had attended chemical dependency treatment one year ago. In addition, R168 was also noted to have had adjustment disorder with disturbance conduct. R168's assessment and plan indicated R168 was agreeable to psychological counseling and amenable to discussion of future treatment option in which the facility social worker would address. R168's care plan dated 6/15/18, indicated R168 had exhibited inappropriate sexual behavior. The plan listed interventions for staff to follow including redirection with inappropriate sexual behaviors, maintain consistent routine, unhurried	F 740	updated for individualized interventions for his behavioral health needs. The changes included discontinuation of one to one monitoring. Resident was again offered AA services which he declined at the current time. Social Worker and relocation worker also met with resident to present customized living (group homes) as an option. This was well received by the resident and the referral process has been implemented. The Behavioral section of the care plan was updated to reflect recent changes per behavioral health interventions and goals. 9-12-18 Identification of Other Residents The interdisciplinary team met with Associated Clinic of Psychiatry to review ACP recommendation process to ensure facility and selected provider have mutual understanding and implementation of the process. 9-14-18 All residents receiving ACP services will be audited to ensure review of recommendations and care planning of individualized behavioral health interventions 10-1-18 Measures Put in Place All Social Workers, Clinical Managers, Therapeutic Activity staff and dieticians will be educated on ACP process and proper follow up required regarding implementation of recommendations and individualized behavioral health care planning. 9-27-18 Monitoring Mechanisms	

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	245242	A. BUILDING _____ B. WING _____	08/23/2018

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F 740	Continued From page 14 time, explain cares and opportunity to express feelings. R168's care plan lacked evidence of person centered individualized behavioral interventions as identified by Associated Clinic of Psychology (ACP) on 8/17/18. In addition, R168's care plan also lacked evidence of person centered individualized alcohol and chemical dependency interventions as ordered by in house physician on 4/19/18. R168's ACP progress notes dated 8/3/18, indicated R168 had frequently been smoking marijuana and R168 was also noted to follow a staff member home who lived near the facility. This note recommended the facility ensure security monitor R168 closely, staff to call police if R168 followed them, reinforce facility drug use policies, arrange for a police officer to come to speak with R168, ensure access to books for reading. The ACP progress notes dated 8/17/18, indicated R168 continued to have reports of drinking, smoking marijuana, sexually inappropriate comments as well as physically threatening statements toward other facility residents. In addition, it indicated that R168 was placed by the facility on a one to one staff ratio. Recommendations were to offer R168 to go on rides and participate in regular activities. R168's progress notes were reviewed: -The note dated 7/30/18, indicated R168 had reported to the facility nurse that he had smoked marijuana; -The note dated 7/31/18, indicated R168 had been observed by the facility social worker and clinical nurse manager, furthermore the note included that the facility would have been required to call the police should R168 smoke marijuana on the premises or at the park;	F 740	Random monthly audits will be conducted for residents receiving ACP services and their individual behavioral health needs by the Social Services department for the next 90 days. 10-1-18 11-1-18 12-1-18 1-1-19 Audits of all residents receiving ACP services will be reviewed by the Quality Improvement Committee for compliance with providing individualized behavioral health interventions and coordination with ACP recommendations. 10-31-18 11-30-18 12-31-18 1-31-19 Responsible Person's Director of Social Services Assistant Director of Social Services Quality Improvement Director	

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F 740	Continued From page 15 - The noted dated 8/8/18, indicated R168 had an empty bottle of vodka and a water bottle filled with vodka. The note included that the facility social worker and clinical nurse manager reiterated the facility alcohol policy; - The note dated 8/13/18, indicated R168 had inappropriately touched a facility staff. The note included that the facility social worker met with R168 and discussed consequences of further incidents; -The note dated 8/17/18, indicated R168 had one to one staff ratio assist during shift. R168's progress notes lacked evidence of follow-up from the facility staff regarding R168's ACP recommendations and continued alcohol/ chemical dependency treatment options as indicated by physician on 4/19/18. Furthermore, R168's records also lacked evidence of physician notification following use of marijuana and ingestion of vodka. During interview on 8/20/18, at 5:25 p.m. R168 stated that he had been placed with a one to one staff due to a verbal altercation with another resident. R168 expressed that he felt as if he was "policed" and did not like the one to one facility staff following him around all day and night. During interview on 8/22/18, at 10:37 a.m. the licensed practical nurse (LPN)-A (also clinical manager) stated that R168 was placed on one to one staff ratio due to an altercation with another resident and inappropriate sexual behavior. LPN-A indicated that when a resident has an issue with chemical dependency or alcohol use the facility made a referral to alcoholics anonymous (AA) classes. LPN-A did not know if R168 had been offered AA classes. LPN-A confirmed R168 had been seen by ACP and that	F 740		

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F 740	Continued From page 16	F 740		

social services received the ACP notes. LPN-A explained that social services reviewed the ACP recommendations and communicated to nursing and activities. LPN-A reviewed ACP note dated 8/3/18 and 8/17/18, however was unable to verify if ACP recommendations had been implemented and stated she would have to check.

During interview on 8/22/18, at 1:16 p.m. the social worker (SS)-A acknowledged R168 had behaviors as outlined in the progress notes. SS-A explained she had followed up with R168 on multiple occasions to explain the facility policy and that R168 had indicated understanding during these conversations. SS-A verbalized R168 was not cognitively intact and had impaired impulsivity, furthermore SS-A stated, she did not think R168 always made good decisions. SS-A explained the ACP recommendations were to be reviewed by her then the recommendations were summarized in an email and sent to the interdisciplinary team including the nursing department, chaplain and activities. SS-A verbalized she was unaware of the expectation regarding follow-up with ACP recommendations and did not know if the recommendation should be included in R168's care plan. SS-A stated each department had taken care of their own ACP recommendations. SS-A indicated any change in a resident's behavior would be added to a spreadsheet and reviewed weekly with ACP. SS-A indicated that ACP was aware of R168's behaviors. SS-A indicated the facility held weekly AA meetings on site, she offered R168 an AA meeting once in August 2018, however R168 refused.

During interview on 8/23/18, at 11:23 a.m. the director of nursing (DON) explained that there

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F 740	Continued From page 17	F 740		

was no formalized policy or procedure for processing ACP recommendations, the ACP recommendations were only suggestions and did not need to be not part of the care plan. DON acknowledged that R168 had been seen by ACP, and her expectation was that the information within the ACP note would be shared with the department in which it directly impacted. DON verbalized she did not know about R168's past history of substance abuse including prior treatment within last year. DON indicated that AA classes should be offered if there was a pattern of intoxication.

On 8/23/18, at 2:02 p.m. R168's ACP provider (ACP-P) was called, and left voicemail message. On 8/24/18, at 8:44 a.m. the ACP provider called back and during interview stated nobody from the facility had updated her about R168's failed attempts regarding behavioral interventions or recommendations. ACP-P explained that she had seen R168 while at the facility and recommended the facility's security officer to monitor R168 closely, staff to reinforce facility drug use policies, arrange for a police officer to come to speak with R168, and ensure access to books. Furthermore, ACP-P stated it was her expectation that she would be notified if one of her recommendations were unsuccessful.

The facility's Psychological Services for Resident policy revised March 2016, indicated "Psychiatric Services follows up with a full report with selected recommendations which is filed in the resident's medical record by Social Services." The policy further noted "The Social Services department shall be delegated the responsibility for coordination of psychological services to include communicating needed

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F 740	Continued From page 18 interventions/recommendations to the interdisciplinary team and assigned NP [nurse practitioner] as needed."	F 740		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were removed from medication storage and locked while waiting for destruction for 8 of 8 residents reviewed (R90, R481, R482, R483,	F 761	F761 It is the policy of the Augustana Health Care Center to store all drugs and biologicals in locked compartments under proper temperature controls, and permit	10/1/18

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F 761	Continued From page 19 R484, R485, R486, R487, R488) whose medications were observed for medication storage. In addition, the facility failed to ensure medication carts were kept locked and secured for 3 of 14 medication carts observed. This had the potential to affect 61 residents of 225 residents who currently resided on four east, three east and three main units. Findings include: On 8/20/18, at 2:57 p.m. during a tour of the first floor medication room, it was noted facility staff included; nurses, trained medication aides, and nursing assistants all had access to the number for the key pad that locked the medication storage room door. The licensed practical nurse (LPN)-A indicated that multiple items were kept in this room to include a coffee pot, water, food for residents and medications. She explained that the medications were kept in locked cupboards and only designated staff had access keys to those cupboards. At 3:00 p.m. a plastic bag with tubes and jars of prescription ointments and creams was identified to be in a cupboard that was not secured with a locked door. LPN-A stated the medications should have been destroyed and they were in the wrong cupboard. She further stated, "they should have been in the locked cupboard" and not available to all the staff who had access to the room. The following items were observed: - A partial tube of Triamcinolone cream (topical steroid) 0.1% for R90, dated 7/27/17. R90 discharge date unknown as records were not found when searched on 8/23/18, at 4:15 p.m. by infection control nurse. - A partial tube of Ketoconazole (topical antifungal) cream 2% for R481, dated 7/15/17.	F 761	only authorized personnel to have access to the keys. Corrective Action All med carts were audited on all shifts for secure locking at all times. All medication rooms cupboards/storage were audited for correct placement of drugs to be destroyed and for secure locking 9-13-18 Identification of Other Needed Actions: All licensed staff and TMA's will be educated per facility standard of locking/securing and proper storage of all medications and biologicals. 10-1-18 Measures Put in Place All med carts will be audited on all shifts one time weekly for the next 30 days and then monthly for the next 90 days. 9-15-18 9-21-18 9-28-18 10-4-18 10-31-18 11-30-18 12-31-18 Monitoring Mechanism Compliance audits for securing of med carts and medication room cupboards/storage will be reviewed for compliance by the Quality Improvement committee to ensure that all drugs and biologicals are stored properly and locked per facility policy. 9-30-18 10-31-18 11-30-18 12-31-18 Responsible Person/s	

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F 761	Continued From page 20 R481 discharged 8/18 /17. - A partial bottle of Ammonium lactate (for dry, scaly, itchy skin conditions) lotion 12% for R482 dated 4/14/17. R482 was discharged 6/15/17. - A partial jar of Gabapentin (topical gel to treat chronic neuropathic pain) gel 8%, for R483 dated 8/20/17. R483 discharged 8/28/17. - Partial tubes of Miconazole (topical antifungal) cream 2% 30 grams and Trolamine salicylate cream 10% for R484 dated 8/6/17. R48 discharged 8/17/17. - Partial tubes of Trolamine salicylate (topical for muscle, joint aches and pains) cream 10% and Nystatin (topical antifungal antibiotic) cream 100,000 for R485 dated 6/14/17. R485 remains in the facility. - Partial tubes of Diclofenac (topical nonsteroidal anti-inflammatory) gel 1%, Acyclovir (topical antiviral) 5% ointment, and Trolamine salicylate (topical for muscle, joint aches and pains) 10% for R486, all dated 7/17/17. R486 discharged 7/27/17. - A partial tube of Nystatin (topical antifungal antibiotic) cream 100,000 for R487 dated 7/12/17. R487 discharged 7/27/17. - A partial tube of Ketoconazole (topical antifungal) cream 2% for R488 dated 7/25/17. R488 discharged 8/4/17. On 8/20/18, at 3:30 p.m. LPN-A removed the tubes, bottle and jar from the first floor medication room and stated she was going to make sure they were destroyed. During a tour of the medication carts on 8/20/18, at 12:20 p.m. the four east medication cart was observed unlocked and unattended by staff. The registered nurse (RN)-A verbalized and confirmed the cart should have been locked when the staff were not present. On 08/20/18, at 12:23 p.m.	F 761	Clinical Managers Director of Nursing Assistant Director of Nursing Quality Improvement Director	

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F 761	Continued From page 21	F 761		

LPN-A stated it was the facility policy to keep the medication carts locked when staff were not directly in front of them for medication administration.

On 8/20/18, at 1:51 p.m. during an observation of medication carts on three east, the trained medication aide (TMA)-A was noted to have left the medication cart unlocked while she was not in the presence of it. At 1:55 p.m. TMA-A stated she should have locked the medication cart prior to leaving it.

On 8/22/18, at 7:40 a.m. while observing a medication pass on four east, RN-A walked away from her medication cart and went down a hallway to administer medications without securing it. At 7:45 a.m., she stated it should have been locked before she walked away from it.

On 8/22/18, at 11:28 a.m. the three main medication cart was noted to be unlocked. There were no staff visible in the area. At 11:30 a.m. LPN-B stated it was the facility's policy to secure or lock the medication cart any time staff walked away from it.

During an interview on 8/23/18, at 11:19 a.m. the director of nursing (DON) stated that all medications that needed to be destroyed should have been kept in the locked cupboards in the medication rooms until they were destroyed. DON also indicated that only nurses and TMA should have had access to the keys for the cabinet where the medications were found. DON further explained all medication carts should have been locked and secured when not in use.

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F 761	Continued From page 22 The facility's Medication Storage policy, dated 4/16, indicated "Only persons authorized to prepare and administer medications shall have access to the medication room, including any keys". In addition, the Pharmaceutical (Medication) Administration Policy, dated revised on 4/16, indicated "Drawers and cupboards with medications in the med room will be kept locked. Medication Cart Key(s) shall be the responsibility of the Med [medication] Nurse/TMA and shall be carried on the person designated for each unit." The policy further noted "Expired or discontinued meds will be removed from med room and destroyed or stored for recycling pick-up as indicated." The facility's medication disposition and destruction of medications policy was requested, and none provided.	F 761		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on August 21, 2018. At the time of this survey, Augustana Health Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/13/2018

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 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Augustana Health Care Center of Minneapolis is a 6-story building with a full basement that was constructed at 3 different times. The original building was constructed in 1945 and was determined to be of Type II(222) construction. In 1968, an addition was constructed to the South side of the building that was determined to be of Type II(222) construction. In 1974, an addition was constructed to the West side of the building that was determined to be of Type II(222) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The facility is fully protected throughout by an automatic fire sprinkler systems	K 000		

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AUGUSTANA HEALTH CARE CENTER OF MINNEAPOLIS	**1007 EAST 14TH STREET MINNEAPOLIS, MN 55404**

(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 000	Continued From page 2 and has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a capacity of 250 beds and had a census of 227 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility's heating, ventilation, and air conditioning in not in compliance with the 2012 LSC NFPA 101 9.2, 19.5.2.1 and NFPA 90A. This deficient practice could effect all 227 residents. Findings include: On a facility tour between the hours of 1000 and 1500 on August 21, 2018, observation revealed that Observation revealed that the ventilation system for the main building appears to be	K 521	F 521 Please see attached annual waiver request for F521 building heating and ventilation equipment. Please see attached vendor letter per unattainable costs associated with waiver	9/17/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245242	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/21/2018**

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K 521	Continued From page 3 utilizing the egress corridor as an exhaust plenum. This deficient practice was verified by the Director of Maintenance at the time of discovery.	K 521		

Name of Facility **2012 LIFE SAFETY CODE**

Augustana HC MPLS 245242

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K400	
K 521 SS=F The building heating, ventilation and air conditioning equipment (HVAC) does not comply with LSC (00) Section 9.2, and NFPA 90A, 1999 Ed., because the corridors are being used as a plenum	An annual/continuing waiver is being requested for K521. A. Compliance with this provision will cause an unreasonable hardship because: 1. The most recent cost estimate dated May 21, 2018 for a complying ducted HVAC system is $2,078,000.00 (See attached letterhead from Metropolitan Mechanical for costs and scope of project work) 2. This project would displace residents for several months, many would need to be transferred out to other facilities as we rarely have available beds in the facility due to census of 92% or higher as a monthly average. This displacement of residents would cause significant emotional distress to residents which could also affect their physical health status in many cases 3. Other projects that would need to occur to support this HVAC system replacement include but are not limited too: a. The building electrical system would need to be upgraded to support a new ducted system. b. The system would also require a new meter at additional costs to the ducted HVAC bid. c. Installation of a ducted system would require asbestos abatement which would also increase the cost. Under the current CMS reimbursement system our costs could not be re-coup as we currently operate at a loss.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* Thomas Linhoff 12424	Title	Office	Date 09-17-2018

Name of Facility **2012 LIFE SAFETY CODE**

Augustana HC MPLS 245242

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K 521 SS=F The building heating, ventilation and air conditioning equipment (HVAC) does not comply with LSC (00) Section 9.2, and NFPA 90A, 1999 Ed., because the corridors are being used as a plenum	An annual/continuing waiver is being requested for K521. A. Compliance with this provision will cause an unreasonable hardship because: 1. The most recent cost estimate dated May 21, 2018 for a complying ducted HVAC system is $2,078,000.00 (See attached letterhead from Metropolitan Mechanical for costs and scope of project work) 2. This project would displace residents for several months, many would need to be transferred out to other facilities as we rarely have available beds in the facility due to census of 92% or higher as a monthly average. This displacement of residents would cause significant emotional distress to residents which could also affect their physical health status in many cases 3. Other projects that would need to occur to support this HVAC system replacement include but are not limited too: a. The building electrical system would need to be upgraded to support a new ducted system. b. The system would also require a new meter at additional costs to the ducted HVAC bid. c. Installation of a ducted system would require asbestos abatement which would also increase the cost. Under the current CMS reimbursement system our costs could not be re-coup as we currently operate at a loss.

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K 521 SS=F The building heating, ventilation and air conditioning equipment (HVAC) does not comply with LSC (00) Section 9.2, and NFPA 90A, 1999 Ed., because the corridors are being used as a plenum	An annual/continuing waiver is being requested for K521. A. Compliance with this provision will cause an unreasonable hardship because: 1. The most recent cost estimate dated May 21, 2018 for a complying ducted HVAC system is $2,078,000.00 (See attached letterhead from Metropolitan Mechanical for costs and scope of project work) 2. This project would displace residents for several months, many would need to be transferred out to other facilities as we rarely have available beds in the facility due to census of 92% or higher as a monthly average. This displacement of residents would cause significant emotional distress to residents which could also affect their physical health status in many cases 3. Other projects that would need to occur to support this HVAC system replacement include but are not limited too: a. The building electrical system would need to be upgraded to support a new ducted system. b. The system would also require a new meter at additional costs to the ducted HVAC bid. c. Installation of a ducted system would require asbestos abatement which would also increase the cost. Under the current CMS reimbursement system our costs could not be re-coup as we currently operate at a loss.

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