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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZFVC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00189

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245556**
2.STATE VENDOR OR MEDICAID NO.
(L2) **376724800**

3. NAME AND ADDRESS OF FACILITY
(L3) **PRESBYTERIAN HOMES OF BLOOMINGTON**
(L4) **9889 PENN AVENUE SOUTH**
(L5) **BLOOMINGTON, MN** (L6) **55431**

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 **03/20/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **98** (L18)
13.Total Certified Beds **98** (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
	98			
(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 :
Gayle Lantto, Unit Supervisor 04/10/2017
(L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/21/2017
(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
04/01/1991
(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
04/06/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245556

June 21, 2017

Ms. Michelle Sullivan, Administrator
Presbyterian Homes Of Bloomington
9889 Penn Avenue South
Bloomington, MN 55431

Dear Ms. Sullivan:

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 March 13, 2017 the above facility is certified for:

98 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 98 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.

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

Sincerely,

Mark Meath

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

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 10, 2017

Ms. Rebecca Ballard, Administrator
Presbyterian Homes Of Bloomington
9889 Penn Avenue South
Bloomington, Minnesota 55431

RE: Project Number S5556029

Dear Ms. Ballard:

On February 21, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 2, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) , whereby corrections were required.

On March 20, 2017, 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 February 2, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 13, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 2, 2017, effective March 13, 2017 and therefore remedies outlined in our letter to you dated February 21, 2017, will not be imposed.

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 related to this eNotice.

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

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
245556 Y1	A. Building B. Wing Y2	3/20/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431

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 F0279	Correction	ID Prefix F0282	Correction	ID Prefix F0309	Correction
Reg. # 483.20(d);483.21(b)(1)	Completed	Reg. # 483.21(b)(3)(ii)	Completed	Reg. # 483.24, 483.25(k)(l)	Completed
LSC	03/13/2017	LSC	03/13/2017	LSC	03/13/2017
ID Prefix F0312	Correction	ID Prefix F0329	Correction	ID Prefix F0334	Correction
Reg. # 483.24(a)(2)	Completed	Reg. # 483.45(d)(e)(1)-(2)	Completed	Reg. # 483.80(d)(1)(2)	Completed
LSC	03/13/2017	LSC	03/13/2017	LSC	03/13/2017
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
☒	GL/mm	04/10/2017	15507	03/20/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/2/2017

☐ 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: ZFVC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00189

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245556**
2.STATE VENDOR OR MEDICAID NO.
(L2) **376724800**

3. NAME AND ADDRESS OF FACILITY
(L3) **PRESBYTERIAN HOMES OF BLOOMINGTON**
(L4) **9889 PENN AVENUE SOUTH**
(L5) **BLOOMINGTON, MN** (L6) **55431**

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 **02/02/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **98** (L18)
13.Total Certified Beds **98** (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
	98			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Lisa Hakanson, HFE NEI 03/08/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/06/2017 (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
04/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5556

On February 2, 2017, a standard survey was completed at the facility by the Minnesota Departments of healthh and Public Safety to determine if the facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in the facility to be 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.

In addition, at the time of the February 2, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5556027 that was found to be unsubstantiated.

Refer to the CMS 2567 forms along with the plan of correction for both health and life safety code. Post Certification Revisit (PCR) to follow.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 21, 2017

Ms. Rebecca Ballard, Administrator
Presbyterian Homes Of Bloomington
9889 Penn Avenue South
Bloomington, Minnesota 55431

RE: Project Number S5556029 and H5556027

Dear Ms. Ballard:

On February 2, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the February 2, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5556027 that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 14, 2017, 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 March 14, 2017 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 May 2, 2017 (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 August 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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

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

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

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

Sincerely,

Mark Meath

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245556	A. BUILDING _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431

(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'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. An investigation into complaint H5556027 was conducted at the time of the Recertification survey and was not substantiated.	F 000		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes	F 279		3/13/17

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

Electronically Signed | 03/02/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245556	A. BUILDING _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431

(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 279	Continued From page 1 to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 279		

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	245556	A. BUILDING _____ B. WING _____	02/02/2017

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F 279	Continued From page 2 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan to develop individualized care plan approaches that included non-pharmacological interventions for 1 of 5 residents (R41) who was reviewed for unnecessary medication use. Findings include: R41's 1/27/17, care plan did not reflect individualized non-pharmacological intervention to help minimize the resident's anxiety symptoms. The plan included consults with pharmacy and physician to evaluate medications, encourage daily routine, monitor target behavior symptoms, and provide enjoyable activities. The only activity specified was working on puzzles. The care plan also had a focus area related to the diagnoses of depression, dementia and anxiety with a fear of dying with interventions including using essential oils as aromatherapy. A 11/28/16, quarterly Minimum Data Set indicated R41's was cognitively intact, had diagnoses including anxiety, depression, and dementia, and utilized daily anti-anxiety and anti-depressant medication. The resident did not display behaviors during the assessment period, however, had occasional mood symptoms. R41's 2/17, physician orders indicated the resident had diagnoses including chronic anxiety disorder, major depressive disorder and dementia. She was prescribed venlafaxine 75 milligrams twice daily for anxiety (antidepressant	F 279	R41□s care plan was reviewed and updated to include the non pharmacological interventions being conducted related to anxiety on 2/2/17. The resident assistant assignment sheet/ care plan were also revised. All resident□s receiving psychotropic medications will have care plans reviewed and updated as indicated to reflect individualized non pharmacological interventions by 2/28/17. All residents are reviewed for individualized care plan interventions upon admission, quarterly, with the onset of a new psychotropic medication and with a significant change in condition in conjunction with the RAI process. Daily IDT meetings are conducted to review behavioral and mood indicators, root cause and the care plans updated as needed. All care plan changes are reviewed with direct care staff through daily assignment sheets, POC documentation and shift report. The policy and procedure related to care planning was reviewed and is current. Education was provided to nursing staff on the psychotropic policy and the use of non pharmacological interventions on 3/7/17 □ 3/10/17. Will complete monthly audits on 10 % of residents receiving psychotropic	

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F 279	Continued From page 3 used to treat major depression and anxiety, order date of 3/14/16) clonazepam 0.5 milligrams twice daily (anticonvulsant commonly used for anxiety, order date 11/29/16) as well as Ativan 0.5 mg every six hours as needed for anxiety (anti-anxiety, order date 11/18/16). Progress notes revealed R41 had been administered as needed Ativan for example on 1/5, 1/17, 1/24, 1/27, and 1/28/17, however, the notes did not reflect non-pharmacological interventions attempted prior to administering the medication. On 2/1/17, at 3:09 p.m. RN-C was interviewed about R41's anxiety, and stated it came on quickly and was difficult to identify triggers. RN-C explained R41 could have been sitting quietly in her room and the next minute was throwing things, slamming the door and saying she was going to die and no one was helping her. Interventions were to try to engage the resident in a quiet activity, use aromatherapy, and ask for help from family when possible. RN-C said when R41 gets so distressed and non-pharmacological interventions did not work, the antianxiety medication Ativan was used. Regarding non-pharmacological interventions used RN-C stated, "We try a lot of things. I know that she does not do well with a lot of activity around her." On 2/2/17, at 10:43 a.m. RN-D produced an updated care plan for R41 which included more individualized non-pharmacological interventions to treat R41's anxiety. RN-D had also updated the treatment record to monitor specific behaviors displayed by R41. The facility's 8/14 Care Plan Policy and	F 279	medications for non pharmacological interventions and updated care plans and report the results to QA committee to determine ongoing frequency of audits and to ensure adequate compliance. The Clinical Administrator is responsible for ongoing compliance. Date certain for compliance is 3/13/17.	

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F 279	Continued From page 4 Procedure indicated the care plan would ensure the resident had the appropriate care required to maintain or attain the resident's highest level of practicable function possible..."interventions should be individualized to the individual and updated as the care changes."	F 279		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 ensure care plans were followed to ensure appropriate grooming for 1 of 4 residents (R25) reviewed for activities of daily living. Findings include: R25's progress note dated 1/19/17, indicated the resident required assistance of one staff with activities of daily living, had impaired vision and wore glasses at all times. It was noted the resident informed staff she was legally blind and utilized a magnifying glass to read. In addition, R25's care plan dated 1/28/17, indicated the resident received twice weekly showers on Mondays and Fridays with staffs' assistance. R25 also required set-up/cues with grooming and oral hygiene. The resident wore glasses, and needed	F 282	R25 had facial hair removed immediately upon notification and resident consent on 2/2/17. The care plan was reviewed and is current. All residents were observed for proper grooming, including facial hair, and that their care plan was being followed on 3/2/17. All residents are provided grooming assistance per the care plan and My Best Day. The care plan for each resident is individually created upon admission and reviewed and updated minimally quarterly and with a change in condition or preference and in conjunction with the RAI process. Rounding occurs each shift by nursing to ensure care and service is being provided to all residents per the care plan.	3/13/17

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F 282	Continued From page 5 staff to guide her or provide verbal instruction as needed due to her visual impairment. The Daily Reports (Nursing Assistant assignment sheets) dated 1/31/17, and updated 2/2/17, directed NAs to "Assist of 1 staff for Groom, Dress." R25 was observed with many short white hairs on her chin on 1/31/17, at 10:40 a.m. and again on 2/1/17, at 7:47 a.m. At 9:26 a.m. R25 was walking in the hallway and to the dining room with the registered physical therapist (RPT). The resident continued to have untrimmed facial hair. In addition, the resident's hair appeared slightly greasy and uncombed, flattened in the back and sticking straight up and out at the sides. The resident was not wearing eye glasses. The RPT informed R25, "I will go get your eye glasses and let your aide know you are here." The RPT returned with R25's eyeglasses. Point of Care (POC) Response History for R25's personal hygiene which included included combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands was reviewed. Documentation reflected R25 received limited assistance on 1/21, 1/22, 1/23, and 1/29/17, on the evening shift. Supervision/oversight/cueing was documented on 1/30/17, evening shift. "Independent--no help or oversight at any time" was documented on the day shift on 1/30 and 1/31/17. The POC for bathing indicated R25 received a bath/shower on 1/20, 1/23, and 1/30/17, on the day shift. On 2/1/17, at 7:48 a.m. nursing assistant (NA)-B reported R25 received a weekly bath or shower twice a week. At 9:11 a.m. on 2/1/17, LPN-A explained facial	F 282	The policy and procedure was reviewed for following the care plan and is current. Education on the AM & HS Cares policy, and the importance of following the care plan/My Best Day and assignment sheets , was provided to all staff on 3/7/17 □ 3/10/17. Will complete weekly grooming audits and care plan audits for minimally 10% of the residents and report the results to the QA committee to determine ongoing frequency of audits and to ensure adequate compliance. The Clinical Administrator is responsible for ongoing compliance Date certain for compliance is 3/13/17.	

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F 282	Continued From page 6	F 282		

hair was trimmed as needed or as a resident desired. NAs were to inform the nurse if a resident refused care so a note could be made in the resident's medical record. Resident individual preferences could be noted on the bottom of the body audit forms. LPN-A stated, "I know if I was unable to, I would want my chin hairs plucked."

On 2/1/17, at 11:27 a.m. NA-B said he had assisted R25 with morning cares. NA-B said he provided supervision as R25 performed her cares in the bathroom. He had observed the resident wash her face and brush her teeth. He did not recall if she brushed her hair, and NA-B stated he had not assisted her to brush her hair. NA-B had not shaved the resident, nor had he asked if she wanted her chin hairs shaved, however, did assist residents to shave if they wanted help. NA-B stated some women may embarrassed to ask for such help. NA-B reported he had noticed R25's facial hair, but had not asked if she wished to be shaved as he had been in a hurry that morning due to a lot of "heavier" cares that needed to be performed. NA-B confirmed R25 wore eyeglasses, but said he had not been scheduled to work with R25.

On 2/2/17, at 9:42 a.m. the health unit coordinator stated, "I just updated these sheets [NA assignments] this morning."

On 2/2/17, at 9:57 a.m. R25 was lying on top of her bed. She was dressed and was wearing her eyeglasses. The facial hair had mostly been removed and R25 smiled and reported, "One of the gals shaved me." R25 stated her preference was to have her chin hairs removed, and said she needed assistance from staff to keep them shaved. At 10:27 a.m. R25 walked in the hallway

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F 282	Continued From page 7 with therapy staff and her hair was again observed flattened and stuck upward on the back of her head. The following day on 2/2/17, at 10:33 a.m. NA-B stated, "I think [LPN-A] shaved R25's chin." NA-C then explained at 10:34 a.m. residents were assisted to shave facial hair daily. NA-C stated she shaved facial hair in the morning, as that made the most sense when getting the residents up for the day. NA-C stated she either asked a resident or the resident requested shaving. NA-C stated if a resident declined care, she would reapproach them later, and if they still did not wish to be shaved, she would inform the nurse so it could be documented. The director of nursing (DON) explained on 2/2/17, at 11:20 a.m. residents were expected to be groomed daily, and shaving was performed per resident preference. The DON stated it was care planned and residents' refusals were charted in POC by the NAs.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management.	F 309		3/13/17

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F 309	Continued From page 8 The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (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,document review and interview the facility failed to identify and ensure care and monitoring was provided for non-pressure related skin conditions for 1 of 3 residents (R107) in the sample observed with bruising. Findings include: R107 was observed with dark purplish colored bruises on resident both hands around the left wrist and on the top of the right hand on 1/31/17 at 9:32 a.m. R107 stated, "It does not bother me. I always get bruised." On 2/1/17, at 7:10 a.m. nursing assistant (NA)-A was observed wheeling R107 to the dining room. A quarterly Minimum Data Set (MDS) dated 12/27/16, revealed R107 had diagnoses including dementia, and had severely impaired cognition with poor recall. The resident required extensive assist of one person with Activity of Daily Living including bed mobility, transferring, and toileting. In addition, the MDS noted R107 had experienced two or more falls since the previous	F 309	R107 was immediately assessed for new bruising upon notification to the nurse and the physician and family were notified. The procedure for monitoring and reporting bruises was initiated. Staff involved in noticing the bruise were immediately re-educated on the notification process. The resident□s care plan was reviewed and updated. A report was made to the state agency immediately upon the supervisor's notification of the bruise by the surveyor who had identified it. All residents are assessed for bruising and alterations in skin daily with cares. All bruises of unknown source, noted for any resident, are immediately reported to the nurse/supervisor, the appropriate state agency, and investigated to determine the root cause per facility policy. The care plans are updated with new interventions. All residents are assessed and care plans are created or reviewed/revised for alterations in skin integrity upon	

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F 309	Continued From page 9 assessment, one with injury and two without injury. No bruises or skin conditions were noted on R107's weekly bath day body audit documentation from 1/3/17 to 1/31/17. R107's care plan revised 1/24/17, identified "I have the potential for alteration in skin integrity due to cognitive impairment, impaired mobility/dependence on others to meet mobility and toileting needs, bowel and bladder incontinence, potential for adverse consequences of medications." Interventions included, "Observe my skin daily and weekly during baths days and report changes to the nurse or NP [nurse practitioner]/MD [medical doctor] as needed." R107's current physician orders for 2/17, included aspirin 81 milligrams, known to contribute to bruising potential. Nursing assistant (NA)-A stated on 2/1/17, at 7:51 a.m. regarding R107's bruises, "Yes, I know about her bruises on her both arms. She is a frequent faller, and I reported it to a nurse--two weeks ago or maybe more--probably [registered nurse (RN)-A]." During an interview with RN-B on 2/1/17, at 8:20 a.m. she stated "I am not sure if the resident has bruises on her hand. Can I check? If there is any noted, I will get back to you." At 3:03 p.m. RN-B confirmed there was no documentation related to R107's current bilateral hand bruises. RN-B stated she was going to complete an incident occurrence report and added, "...and this is going to be an educational opportunity for the staff. It should have been reported." RN-B explained the	F 309	admission, minimally quarterly or with a significant change in condition in conjunction with the RAI process. The facility policy for Skin Integrity Management and the Vulnerable Adult Reporting Policy were reviewed and are current. Education was provided to staff on the Skin Integrity Management Policy and the procedure for reporting a newly identified bruise on 3/7/17 - 3/10/17. Skin audits will be conducted weekly for 4 weeks on all residents along with occurrence reports being reviewed weekly at IDT to ensure proper reporting. The results of the audits will be reported to the QA committee to determine ongoing frequency of audits and to ensure adequate compliance. The Clinical Administrator is responsible for ongoing compliance. Date certain is 3/13/2017	

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facility's process was that when a bruise was identified, staff was supposed to document on a blue form, "...but this wasn't done. I have completed the occurrence report now. I also updated the care plan indicating the resident easily bruised, was on aspirin, and need to be monitored. We will monitor the bruise daily until it heals."

On 2/2/17, at 9:25 a.m. the director of nursing (DON) stated, "I would expect the staff to assess, document and properly report." The DON said once the team was made aware of the bruises by the surveyor, they assessed and documented the presence of the bruises. The DON explained, "Staff are instructed to notify the nurses when they notice any bruises. I guess the bruise was not identified...it will require some additional staff training on our policy and procedure."

During an interview with RN-A on 2/2/17 at 10:47 a.m. regarding R107's bruises, "I just knew this morning. My supervisor updated me on bruises...I have never done body audit for her. She takes bath two times a week and we only do one body audit once a week during the bath. The body audit is done on my day off day." RN-A stated no one brought R107's bruises to her attention until that morning. She also stated she sometimes assisted the NAs with toileting residents, but said, "I do not remember seeing bruises on her hand."

The facility's 1/17, Skin Integrity Management Policy noted, "It is the policy of Presbyterian Home to properly identify, assess and Monitor residents whose clinical conditions increase the risk for impaired skin integrity...to implement preventative measures and to provide appropriate treatment modalities for pressure ulcers/injuries

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F 309	Continued From page 11 according to industry standard of care."	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide grooming assistance for 1 of 4 residents (R25) reviewed for activities of daily living. Findings include: R25 was observed with many short white hairs on her chin on 1/31/17, at 10:40 a.m. and again on 2/1/17, at 7:47 a.m. At 9:26 a.m. R25 was walking in the hallway and to the dining room with the registered physical therapist (RPT). The resident continued to have untrimmed facial hair. In addition, the resident's hair appeared slightly greasy and uncombed, flattened in the back and sticking straight up and out at the sides. The resident was not wearing eye glasses. The RPT informed R25, "I will go get your eye glasses and let your aide know you are here." The RPT returned with R25's eyeglasses. A progress note dated 1/19/17, indicated R25 required assistance of one staff with activities of daily living, had impaired vision and wore glasses at all times. It was noted the resident informed staff she was legally blind and utilized a magnifying glass to read.	F 312	R25 had facial hair removed immediately and grooming provided upon notification and resident consent on 2/2/17. The care plan was reviewed and is current. All residents were observed for proper grooming, including removal of unwanted facial hair and that their care plan was being followed on 3/2/17. All residents are provided grooming assistance per the care plan and My Best Day. The care plan for each resident is individually created upon admission and reviewed and updated minimally quarterly and with a change in condition or preference and in conjunction with the RAI process. Rounding occurs each shift by nursing to ensure care and service is being provided to all residents per the care plan. The policy and procedure was reviewed for following the care plan and is current. Education on the AM & HS Cares policy, and the importance of following the care plan/My Best Day and assignment sheets, was provided to all staff on 3/7/17 - 3/10/17.	3/13/17

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F 312	Continued From page 12 R25's care plan dated 1/28/17, indicated R25 received twice weekly showers on Mondays and Fridays with staffs' assistance. R25 also required set-up/cues with grooming and oral hygiene. The resident wore glasses, and needed staff to guide her or provide verbal instruction as needed due to her visual impairment. The Daily Reports (Nursing Assistant assignment sheets) dated 1/31/17, and updated 2/2/17, directed NAs to "Assist of 1 staff for Groom, Dress." Point of Care (POC) Response History for R25's personal hygiene which included included combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands was reviewed. Documentation reflected R25 received limited assistance on 1/21, 1/22, 1/23, and 1/29/17, on the evening shift. Supervision/oversight/cueing was documented on 1/30/17, evening shift. "Independent--no help or oversight at any time" was documented on the day shift on 1/30 and 1/31/17. The POC for bathing indicated R25 received a bath/shower on 1/20, 1/23, and 1/30/17, on the day shift. On 2/1/17, at 7:48 a.m. nursing assistant (NA)-B reported R25 received a weekly bath or shower twice a week. At 9:11 a.m. on 2/1/17, LPN-A explained R25 was working with therapy and had recently been hospitalized for pneumonia. At 10:23 a.m. LPN-A stated residents were scheduled twice weekly for a tub bath or shower unless they chose more frequent bathing. LPN-A explained facial hair was trimmed as needed or as a resident desired. NAs were to inform the nurse if a resident refused	F 312	Will complete weekly grooming audits and care plan audits for minimally 10% of the residents and report the results to the QA committee to determine ongoing frequency of audits and to ensure adequate compliance. The Clinical Administrator is responsible for ongoing compliance Date certain for compliance is 3/13/17.	

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	245556	A. BUILDING _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431

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F 312	Continued From page 13	F 312		

care so a note could be made in the resident's medical record. Resident individual preferences could be noted on the bottom of the body audit forms. LPN-A stated, "I know if I was unable to, I would want my chin hairs plucked."

On 2/1/17, at 11:27 a.m. NA-B said he had assisted R25 with morning cares. NA-B said he provided supervision as R25 performed her cares in the bathroom. He had observed the resident wash her face and brush her teeth. He did not recall if she brushed her hair, and NA-B stated he had not assisted her to brush her hair. NA-B had not shaved the resident, nor had he asked if she wanted her chin hairs shaved, however, did assist residents to shave if they wanted help. NA-B stated some women may embarrassed to ask for such help. NA-B reported he had noticed R25's facial hair, but had not asked if she wished to be shaved as he had been in a hurry that morning due to a lot of "heavier" cares that needed to be performed. NA-B confirmed R25 wore eyeglasses, but said he had not been scheduled to work with R25.

On 2/2/17, at 9:42 a.m. the health unit coordinator stated, "I just updated these sheets [NA assignments] this morning."

On 2/2/17, at 9:57 a.m. R25 was lying on top of her bed. She was dressed and was wearing her eyeglasses. The facial hair had mostly been removed and R25 smiled and reported, "One of the gals shaved me." R25 stated her preference was to have her chin hairs removed, and said she needed assistance from staff to keep them shaved. At 10:27 a.m. R25 walked in the hallway with therapy staff and her hair was again observed flattened and stuck upward on the back

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F 312	Continued From page 14 of her head. The following day on 2/2/17, at 10:33 a.m. NA-B stated, "I think [LPN-A] shaved R25's chin." NA-C then explained at 10:34 a.m. residents were assisted to shave facial hair daily. NA-C stated she shaved facial hair in the morning, as that made the most sense when getting the residents up for the day. NA-C stated she either asked a resident or the resident requested shaving. NA-C stated if a resident declined care, she would reapproach them later, and if they still did not wish to be shaved, she would inform the nurse so it could be documented. The director of nursing (DON) explained on 2/2/17, at 11:20 a.m. residents were expected to be groomed daily, and shaving was performed per resident preference. The DON stated it was care planned and residents' refusals were charted in POC by the NAs. The facility's 9/15, Cares AM and HS (hour of sleep) policy directed staff, "Every resident is to have AM and HS cares done daily...Nursing Assistant Assignment Sheet for the amount of assistance required to provide care and resident's ability to participate...Comb resident's hair in am...Shave Residents in am and apply makeup to female guests as requested."	F 312		
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--	F 329		3/13/17

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F 329	Continued From page 15 (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to document the rationale for the use of as needed anti-anxiety medication for 1 of 5 residents (R41) reviewed for unnecessary medication use. Findings include: R41 observed lying in her bed on 2/2/17, at 12:40 p.m. R41 reported she wished to stay in bed and not go to the dining room for lunch as she felt terrible and angry. R41 had an anxious look on her face and was coughing slightly. Registered nurse (RN)-E was reassuring R41 and encouraging her to deep breathe. A 11/28/16, quarterly Minimum Data Set indicated R41's was cognitively intact, had diagnoses including anxiety, depression, and dementia, and utilized daily anti-anxiety and anti-depressant medication. The resident did not display behaviors during the assessment period,	F 329	R41 was re-assessed for the ongoing need of anti- anxiety medication and interventions to reduce anxiety. R 41□s care plan was updated on 2/2/17 for the rationale for the use of an anti- anxiety medication and the use of non pharmacological interventions. Each resident□s drug regimen is assessed to ensure that they are free from unnecessary drugs and that there is appropriate monitoring. All residents are assessed upon admission, reviewed minimally quarterly or with a change in psychoactive medication. Resident□s noted to have changes in mood or behaviors are reviewed daily at IDT. All care plans are reviewed upon admission, minimally quarterly and with a change in status. All resident□s receiving psychotropic medications on an as needed basis will be reviewed for non	

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F 329	Continued From page 16 however, had occasional mood symptoms. R41's 2/17, physician orders indicated the resident had diagnoses including chronic anxiety disorder, major depressive disorder and dementia. She was prescribed venlafaxine 75 milligrams twice daily for anxiety (antidepressant used to treat major depression and anxiety, order date of 3/14/16) clonazepam 0.5 milligrams twice daily (anticonvulsant commonly used for anxiety, order date 11/29/16) as well as Ativan 0.5 mg every six hours as needed for anxiety (anti-anxiety, order date 11/18/16). Progress notes revealed R41 had been administered as needed Ativan for example on 1/5, 1/17, 1/24, 1/27, and 1/28/17, however, the notes did not reflect non-pharmacological interventions attempted prior to administering the medication. R41's 1/27/17, care plan did not reflect individualized non-pharmacological intervention to help minimize the resident's anxiety symptoms. On 2/1/17, at 3:09 p.m. RN-C was interviewed about R41's anxiety, and stated it came on quickly and was difficult to identify triggers. RN-C explained R41 could have been sitting quietly in her room and the next minute was throwing things, slamming the door and saying she was going to die and no one was helping her. Interventions were to try to engage the resident in a quiet activity, use aromatherapy, and ask for help from family when possible. RN-C said when R41 gets so distressed and non-pharmacological interventions did not work, the antianxiety medication Ativan was used. Regarding non-pharmacological interventions used RN-C stated, "We try a lot of things. I know that she	F 329	pharmacological interventions and the appropriate use of PRN medication by 2/28/17. The pharmacist consultant reviews all residents monthly for appropriate use of medications and provides recommendations to physicians and staff as indicated. The policy and procedure for unnecessary medications was reviewed and is current. Education on the psychotropic policy, the need for adequate monitoring, indication for use, and the use of non pharm interventions was provided to staff on 3/7/17 □ 3/10/17 Nursing will complete monthly audits on residents receiving psychotropic medications and report the results to the QA committee to determine ongoing frequency of audits and to ensure adequate compliance. The Clinical Administrator is responsible for ongoing compliance. Date certain is 3/13/17.	

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F 329	Continued From page 17 does not do well with a lot of activity around her." On 2/1/17, at 3:27 p.m. RN-D explained R41 could become anxious over swallowing, and they tried fluids, cough syrup, deep breathing, and relaxing music. If the interventions did not work, they administered Ativan. R41's 1/17, medication administration record (MAR) was reviewed with RN-D. R41 was given Ativan seven times in the month, however, nursing documentation did not include information as to non-pharmacological interventions that had been attempted prior to its administration. RN-D verified the staff should have documented non-pharmacological interventions they had attempted. RN-E explained on 2/2/17, at 12:35 p.m. R41's anxiety had become even worse and approaches included offering reassurance, wheeling her in her wheelchair, music, aromatherapy, and puzzles, however lately had been refusing puzzles. A consultant pharmacist's (CP) recommendation dated 12/29/16, requested the facility document which non-pharmacological interventions were tried prior to Ativan administration. The CP was interviewed on 2/2/17, at 1:30 p.m. She explained at the time of the review she would have been looking for more information regarding staffs' interventions utilized, and felt documentation was lacking in this regard in R41's medical record. The facility's 5/16, Psychoactive Medication and Unnecessary Medication Use Policy, indicated each resident's drug regimen was to be free from unnecessary drugs, which included any drug without adequate indications for use. hen used without adequate monitoring.	F 329		

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F 334 SS=E	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's 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 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 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. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal	F 334		3/13/17

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F 334	Continued From page 19 immunization, each resident or the resident's 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 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 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure pneumococcal vaccination was offered for 4 of 5 residents reviewed (R122, R41, R121, R107) who were over 65 and whose vaccination records were reviewed. Findings include: The Centers for Disease Control (CDC), recommendations included pneumococcal vaccination for all persons 65 years of age, or	F 334	R41 no longer resides in facility. R122, R121, R107 providers were contacted to order appropriate vaccine on 2/24/17. Identified residents received pneumococcal vaccine as indicated by physicians order and consent. All current residents immunization status was reviewed and updated per facility policy by 2/28/17. Orders were received and vaccine administered as per order	

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F 334	Continued From page 20 sooner based on a health evaluation. Vaccination with Prevnar 13 (PCV13) should have been offered one year after a Pneumovax 23 (PPSV23) and PCV13, if the PPSV23 was given at 65 years or older. R122's immunization record revealed "Pneumovax dose 1" was administered on 4/27/05. The record lacked indication of which type of vaccine was administered in 2005, and lacked evidence further vaccination was offered. R41's immunization record revealed "Pneumovax Dose 1" administered on 12/28/09. The record lacked indication of which type of vaccine was administered in 2009, and lacked evidence further vaccination was offered. R121's immunization record revealed "Pneumovax Dose 1" was administered on 1/1/97. The record lacked indication of which type of vaccine was administered in 1997, and lacked evidence further vaccination was offered. R107's immunization record revealed "Pneumovax Dose 1" was administered on 10/1/09. The record lacked indication of which type of vaccine was administered in 2009, and lacked evidence further vaccination was offered. The director of nursing (DON) was interviewed on 2/2/17, at 12:00 p.m. regarding the facility's process to ensure residents were offered recommended Pneumovax 23 (PPSV23) and Prevnar 13 (PCV13) pneumococcal vaccination. He explained the facility followed the approved protocol for administration of the vaccines. To determine a resident's vaccination status they requested vaccination records from the resident's	F 334	and consent. All residents vaccine history is reviewed upon admission and in conjunction with the RAI process. Physicians, residents, and families are updated regarding recommendations per facility policy. The facility pneumococcal policy was reviewed and is current. Education on the Pneumococcal/Influenza policy was provided to staff on 3/7/17 3/10/17. The resident spreadsheet was initiated. An audit of the immunization log will be conducted monthly and the results with be reported to the QA committee to determine ongoing frequency of audits and to ensure adequate compliance. The Clinical Administrator is responsible for ongoing compliance. Date certain is 3/13/17	

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F 334	Continued From page 21 clinic, used the State's database and interviewed the resident. For short stay residents, they allowed the resident's physician to recommend and administer the vaccines. The facility's 5/16, vaccination policy indicated each resident would be offered the pneumococcal immunization unless there was a medical reason for not giving the vaccine or if the resident declined or had already received the recommended vaccines. Each resident's pneumococcal immunization status would be determined upon admission and documented in the medical record. Education would be provided to the resident or responsible party and informed consent or refusal obtained. The facility would follow CDC recommendations for administration of the vaccines.	F 334		

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

F5556026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245556	A. BUILDING **1N - NEW BUILDING** B. WING _____	**02/03/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on February 03, 2017. At the time of this survey, Presbyterian Homes of Bloomington Care Center was found 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. Presbyterian Homes of Bloomington Care Center was built in 2005 and is a 3-story building that was determined to be of Type II(222) construction. It has a full basement and is fully automatic fire sprinklered. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 98 beds and had a census of 96 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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.

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 21, 2017

Ms. Rebecca Ballard, Administrator
Presbyterian Homes Of Bloomington
9889 Penn Avenue South
Bloomington, Minnesota 55431

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5556029 and H5556027

Dear Ms. Ballard:

The above facility was surveyed on January 30, 2017 through February 2, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5556027. 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 immediately contact Gayle Lantto at: (651) 201-3794 or email: gayle.lantto@state.mn.us**.

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.

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

Sincerely,

Mark Meath

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

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

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	00189	A. BUILDING: _____ B. WING _____	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431

(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: 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00189	A. BUILDING: _____ B. WING _____	02/02/2017

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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 January 30 through February 2, 2017, 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.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. An investigation into complaint H5556027 was conducted at the time of the State Licensing survey and was not substantiated.	2 000		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed 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. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan to develop individualized care plan approaches that included non-pharmacological interventions for 1 of 5 residents (R41) who was reviewed for unnecessary medication use. Findings include:	2 555	Corrected	3/13/17

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2 555	Continued From page 3 R41's 1/27/17, care plan did not reflect individualized non-pharmacological intervention to help minimize the resident's anxiety symptoms. The plan included consults with pharmacy and physician to evaluate medications, encourage daily routine, monitor target behavior symptoms, and provide enjoyable activities. The only activity specified was working on puzzles. The care plan also had a focus area related to the diagnoses of depression, dementia and anxiety with a fear of dying with interventions including using essential oils as aromatherapy. A 11/28/16, quarterly Minimum Data Set indicated R41's was cognitively intact, had diagnoses including anxiety, depression, and dementia, and utilized daily anti-anxiety and anti-depressant medication. The resident did not display behaviors during the assessment period, however, had occasional mood symptoms. R41's 2/17, physician orders indicated the resident had diagnoses including chronic anxiety disorder, major depressive disorder and dementia. She was prescribed venlafaxine 75 milligrams twice daily for anxiety (antidepressant used to treat major depression and anxiety, order date of 3/14/16) clonazepam 0.5 milligrams twice daily (anticonvulsant commonly used for anxiety, order date 11/29/16) as well as Ativan 0.5 mg every six hours as needed for anxiety (anti-anxiety, order date 11/18/16). Progress notes revealed R41 had been administered as needed Ativan for example on 1/5, 1/17, 1/24, 1/27, and 1/28/17, however, the notes did not reflect non-pharmacological interventions attempted prior to administering the medication.	2 555		

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2 555	Continued From page 4 On 2/1/17, at 3:09 p.m. RN-C was interviewed about R41's anxiety, and stated it came on quickly and was difficult to identify triggers. RN-C explained R41 could have been sitting quietly in her room and the next minute was throwing things, slamming the door and saying she was going to die and no one was helping her. Interventions were to try to engage the resident in a quiet activity, use aromatherapy, and ask for help from family when possible. RN-C said when R41 gets so distressed and non-pharmacological interventions did not work, the antianxiety medication Ativan was used. Regarding non-pharmacological interventions used RN-C stated, "We try a lot of things. I know that she does not do well with a lot of activity around her." On 2/2/17, at 10:43 a.m. RN-D produced an updated care plan for R41 which included more individualized non-pharmacological interventions to treat R41's anxiety. RN-D had also updated the treatment record to monitor specific behaviors displayed by R41. The facility's 8/14 Care Plan Policy and Procedure indicated the care plan would ensure the resident had the appropriate care required to maintain or attain the resident's highest level of practicable function possible..."interventions should be individualized to the individual and updated as the care changes." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could ensure policies are current and are implemented related to developing individualized care plans. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. Audits could be conducted and the	2 555		

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2 555	Continued From page 5 results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555		
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 care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care plans were followed to ensure appropriate grooming for 1 of 4 residents (R25) reviewed for activities of daily living. Findings include: R25's progress note dated 1/19/17, indicated the resident required assistance of one staff with activities of daily living, had impaired vision and wore glasses at all times. It was noted the resident informed staff she was legally blind and utilized a magnifying glass to read. In addition, R25's care plan dated 1/28/17, indicated the resident received twice weekly showers on Mondays and Fridays with staffs' assistance. R25 also required set-up/cues with grooming and oral hygiene. The resident wore glasses, and needed staff to guide her or provide verbal instruction as needed due to her visual impairment. The Daily	2 565	Corrected	3/13/17

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2 565	Continued From page 6 Reports (Nursing Assistant assignment sheets) dated 1/31/17, and updated 2/2/17, directed NAs to "Assist of 1 staff for Groom, Dress." R25 was observed with many short white hairs on her chin on 1/31/17, at 10:40 a.m. and again on 2/1/17, at 7:47 a.m. At 9:26 a.m. R25 was walking in the hallway and to the dining room with the registered physical therapist (RPT). The resident continued to have untrimmed facial hair. In addition, the resident's hair appeared slightly greasy and uncombed, flattened in the back and sticking straight up and out at the sides. The resident was not wearing eye glasses. The RPT informed R25, "I will go get your eye glasses and let your aide know you are here." The RPT returned with R25's eyeglasses. Point of Care (POC) Response History for R25's personal hygiene which included included combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands was reviewed. Documentation reflected R25 received limited assistance on 1/21, 1/22, 1/23, and 1/29/17, on the evening shift. Supervision/oversight/cueing was documented on 1/30/17, evening shift. "Independent--no help or oversight at any time" was documented on the day shift on 1/30 and 1/31/17. The POC for bathing indicated R25 received a bath/shower on 1/20, 1/23, and 1/30/17, on the day shift. On 2/1/17, at 7:48 a.m. nursing assistant (NA)-B reported R25 received a weekly bath or shower twice a week. At 9:11 a.m. on 2/1/17, LPN-A explained facial hair was trimmed as needed or as a resident desired. NAs were to inform the nurse if a resident refused care so a note could be made in	2 565		

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2 565	Continued From page 7	2 565		

the resident's medical record. Resident individual preferences could be noted on the bottom of the body audit forms. LPN-A stated, "I know if I was unable to, I would want my chin hairs plucked."

On 2/1/17, at 11:27 a.m. NA-B said he had assisted R25 with morning cares. NA-B said he provided supervision as R25 performed her cares in the bathroom. He had observed the resident wash her face and brush her teeth. He did not recall if she brushed her hair, and NA-B stated he had not assisted her to brush her hair. NA-B had not shaved the resident, nor had he asked if she wanted her chin hairs shaved, however, did assist residents to shave if they wanted help. NA-B stated some women may embarrassed to ask for such help. NA-B reported he had noticed R25's facial hair, but had not asked if she wished to be shaved as he had been in a hurry that morning due to a lot of "heavier" cares that needed to be performed. NA-B confirmed R25 wore eyeglasses, but said he had not been scheduled to work with R25.

On 2/2/17, at 9:42 a.m. the health unit coordinator stated, "I just updated these sheets [NA assignments] this morning."

On 2/2/17, at 9:57 a.m. R25 was lying on top of her bed. She was dressed and was wearing her eyeglasses. The facial hair had mostly been removed and R25 smiled and reported, "One of the gals shaved me." R25 stated her preference was to have her chin hairs removed, and said she needed assistance from staff to keep them shaved. At 10:27 a.m. R25 walked in the hallway with therapy staff and her hair was again observed flattened and stuck upward on the back of her head.

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2 565	Continued From page 8 The following day on 2/2/17, at 10:33 a.m. NA-B stated, "I think [LPN-A] shaved R25's chin." NA-C then explained at 10:34 a.m. residents were assisted to shave facial hair daily. NA-C stated she shaved facial hair in the morning, as that made the most sense when getting the residents up for the day. NA-C stated she either asked a resident or the resident requested shaving. NA-C stated if a resident declined care, she would reapproach them later, and if they still did not wish to be shaved, she would inform the nurse so it could be documented. The director of nursing (DON) explained on 2/2/17, at 11:20 a.m. residents were expected to be groomed daily, and shaving was performed per resident preference. The DON stated it was care planned and residents' refusals were charted in POC by the NAs. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could update policies as needed. Appropriate staff could be trained as to how to ensure care plans are followed for each resident. Observations could be conducted. Audits could be conducted to ensure compliance and the results brought to the quality committee for review. 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	2 830		3/13/17

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2 830	Continued From page 9 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: Based on observation, interview and document review, the facility failed to ensure eye glasses were worn for 1 of 1 resident (R25) who reported she was legally blind. Findings include: R25 was observed on 1/31/17, at 10:40 a.m. and again on 2/1/17, at 7:47 a.m. and 9:26 a.m. R25 was walking in the hallway and to the dining room with the registered physical therapist (RPT). The resident was not wearing eye glasses. The RPT informed R25, "I will go get your eye glasses and let your aide know you are here." The RPT returned with R25's eyeglasses. A progress note dated 1/19/17, indicated R25 required assistance of one staff with activities of daily living, had impaired vision and wore glasses at all times. It was noted the resident informed staff she was legally blind and utilized a magnifying glass to read. R25's care plan dated 1/28/17, indicated R25 wore glasses, and needed staff to guide her or provide verbal instruction as needed due to her visual impairment.	2 830	Corrected	

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2 830	Continued From page 10 On 2/1/17, at 11:27 a.m. NA-B said he had assisted R25 with morning cares. NA-B confirmed R25 wore eyeglasses, but said he had not been scheduled to work with R25 on 1/31/17. On 2/2/17, at 9:57 a.m. R25 was lying on top of her bed. She was wearing her eyeglasses. The director of nursing (DON) explained on 2/2/17, at 11:20 a.m. residents were expected to be groomed daily. The facility's 9/15, Cares AM and HS (hour of sleep) policy directed staff, "Every resident is to have AM and HS cares done daily...Nursing Assistant Assignment Sheet for the amount of assistance required to provide care and resident's ability to participate." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could update policies as needed. Appropriate staff could be trained to ensure residents who have eye glasses are provided with those devices. Observations and audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 830		
2 845	MN Rule 4658.0520 Subp. 2 C Adequate and Proper Nursing Care; Shampoo Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: C. A shampoo at least weekly and assistance with daily hair grooming as needed.	2 845		3/13/17

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2 845	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide hair care for 1 of 4 residents (R25) reviewed for activities of daily living. Findings include: R25 was observed on 1/31/17, at 10:40 a.m. and again on 2/1/17, at 7:47 a.m. and 9:26 a.m. During the observations, R25's hair appeared slightly greasy and uncombed, flattened in the back and sticking straight up and out at the sides. A progress note dated 1/19/17, indicated R25 required assistance of one staff with activities of daily living. R25's care plan dated 1/28/17, indicated R25 received twice weekly showers on Mondays and Fridays with staffs' assistance. R25 also required set-up/cues with grooming. The Daily Reports (Nursing Assistant assignment sheets) dated 1/31/17, and updated 2/2/17, directed NAs to "Assist of 1 staff for Groom, Dress." Point of Care (POC) Response History for R25's personal hygiene which included included combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands was reviewed. Documentation reflected R25 received limited assistance on 1/21, 1/22, 1/23, and 1/29/17, on the evening shift. Supervision/oversight/cueing was documented on 1/30/17, evening shift. "Independent--no help or oversight at any time" was documented on the day shift on 1/30 and 1/31/17. The POC for bathing indicated R25 received a bath/shower on 1/20, 1/23, and 1/30/17, on the day shift.	2 845	Corrected	

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2 845	Continued From page 12 On 2/1/17, at 7:48 a.m. nursing assistant (NA)-B reported R25 received a weekly bath or shower twice a week. LPN-A explained on 2/1/17, at 10:23 a.m. residents were scheduled twice weekly for a tub bath or shower unless they chose more frequent bathing. On 2/1/17, at 11:27 a.m. NA-B said he had assisted R25 with morning cares. NA-B said he provided supervision as R25 performed her cares in the bathroom. He had observed the resident wash her face and brush her teeth. He did not recall if she brushed her hair, and NA-B stated he had not assisted her to brush her hair. On 2/2/17, at 10:27 a.m. R25 was observed in the hallway walked in the hallway with therapy staff and her hair was again observed flattened and stuck upward on the back of her head. The director of nursing (DON) explained on 2/2/17, at 11:20 a.m. residents were expected to be groomed daily and would be care planned, with residents' refusals charted in POC by the NAs. The facility's 9/15, Cares AM and HS (hour of sleep) policy directed staff, "Every resident is to have AM and HS cares done daily...Nursing Assistant Assignment Sheet for the amount of assistance required to provide care and resident's ability to participate...Comb resident's hair in am." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could update policies as needed. Appropriate staff could be trained. Observations and audits could be	2 845		

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2 845	Continued From page 13 conducted to ensure residents' hair is shampooed and combed and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 845		
2 850	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide grooming assistance for 1 of 4 residents (R25) reviewed for activities of daily living. Findings include: R25 was observed with many short white hairs on her chin on 1/31/17, at 10:40 a.m. and again on 2/1/17, at 7:47 a.m. At 9:26 a.m. R25 was walking in the hallway and to the dining room with the registered physical therapist (RPT). A progress note dated 1/19/17, indicated R25 required assistance of one staff with activities of daily living. R25's care plan dated 1/28/17, indicated R25 required set-up/cues with grooming. The Daily Reports (Nursing Assistant	2 850	Corrected	3/13/17

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	00189	A. BUILDING: _____ B. WING _____	02/02/2017

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2 850	Continued From page 14 assignment sheets) dated 1/31/17, and updated 2/2/17, directed NAs to "Assist of 1 staff for Groom, Dress." Point of Care (POC) Response History for R25's personal hygiene which included included combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands was reviewed. Documentation reflected R25 received limited assistance on 1/21, 1/22, 1/23, and 1/29/17, on the evening shift. Supervision/oversight/cueing was documented on 1/30/17, evening shift. "Independent--no help or oversight at any time" was documented on the day shift on 1/30 and 1/31/17. On 2/1/17, at 10:23 a.m. LPN-A explained facial hair was trimmed as needed or as a resident desired. NAs were to inform the nurse if a resident refused care so a note could be made in the resident's medical record. Resident individual preferences could be noted on the bottom of the body audit forms. LPN-A stated, "I know if I was unable to, I would want my chin hairs plucked." On 2/1/17, at 11:27 a.m. NA-B said he had assisted R25 with morning cares. NA-B said he provided supervision as R25 performed her cares in the bathroom. NA-B had not shaved the resident, nor had he asked if she wanted her chin hairs shaved, however, did assist residents to shave if they wanted help. NA-B stated some women may be embarrassed to ask for such help. NA-B reported he had noticed R25's facial hair, but had not asked if she wished to be shaved as he had been in a hurry that morning due to a lot of "heavier" cares that needed to be performed. On 2/2/17, at 9:57 a.m. R25 was lying on top of	2 850		

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2 850	Continued From page 15 her bed. Her facial hair had mostly been removed and R25 smiled and reported, "One of the gals shaved me." R25 stated her preference was to have her chin hairs removed, and said she needed assistance from staff to keep them shaved. The following day on 2/2/17, at 10:33 a.m. NA-B stated, "I think [LPN-A] shaved R25's chin." NA-C then explained at 10:34 a.m. residents were assisted to shave facial hair daily. NA-C stated she shaved facial hair in the morning, as that made the most sense when getting the residents up for the day. NA-C stated she either asked a resident or the resident requested shaving. NA-C stated if a resident declined care, she would reapproach them later, and if they still did not wish to be shaved, she would inform the nurse so it could be documented. The director of nursing (DON) explained on 2/2/17, at 11:20 a.m. residents were expected to be groomed daily, and shaving was performed per resident preference. The DON stated it was care planned and residents' refusals were charted in POC by the NAs. The facility's 9/15, Cares AM and HS (hour of sleep) policy directed staff, "Every resident is to have AM and HS cares done daily...Nursing Assistant Assignment Sheet for the amount of assistance required to provide care and resident's ability to participate..Shave Residents in am...." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could update policies as needed. Appropriate staff could be trained. Observations and audits could be conducted to ensure residents are shaved according to their preferences. The results could	2 850		

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2 850	Continued From page 16 be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 850		
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 document the rationale for the use of as needed anti-anxiety medication for 1 of 5 residents (R41) reviewed for unnecessary medication use.	21540	Corrected	3/13/17

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21540	Continued From page 17 Findings include: R41 observed lying in her bed on 2/2/17, at 12:40 p.m. R41 reported she wished to stay in bed and not go to the dining room for lunch as she felt terrible and angry. R41 had an anxious look on her face and was coughing slightly. Registered nurse (RN)-E was reassuring R41 and encouraging her to deep breathe. A 11/28/16, quarterly Minimum Data Set indicated R41's was cognitively intact, had diagnoses including anxiety, depression, and dementia, and utilized daily anti-anxiety and anti-depressant medication. The resident did not display behaviors during the assessment period, however, had occasional mood symptoms. R41's 2/17, physician orders indicated the resident had diagnoses including chronic anxiety disorder, major depressive disorder and dementia. She was prescribed venlafaxine 75 milligrams twice daily for anxiety (antidepressant used to treat major depression and anxiety, order date of 3/14/16) clonazepam 0.5 milligrams twice daily (anticonvulsant commonly used for anxiety, order date 11/29/16) as well as Ativan 0.5 mg every six hours as needed for anxiety (anti-anxiety, order date 11/18/16). Progress notes revealed R41 had been administered as needed Ativan for example on 1/5, 1/17, 1/24, 1/27, and 1/28/17, however, the notes did not reflect non-pharmacological interventions attempted prior to administering the medication. R41's 1/27/17, care plan did not reflect individualized non-pharmacological intervention to help minimize the resident's anxiety symptoms.	21540		

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21540	Continued From page 18 On 2/1/17, at 3:09 p.m. RN-C was interviewed about R41's anxiety, and stated it came on quickly and was difficult to identify triggers. RN-C explained R41 could have been sitting quietly in her room and the next minute was throwing things, slamming the door and saying she was going to die and no one was helping her. Interventions were to try to engage the resident in a quiet activity, use aromatherapy, and ask for help from family when possible. RN-C said when R41 gets so distressed and non-pharmacological interventions did not work, the antianxiety medication Ativan was used. Regarding non-pharmacological interventions used RN-C stated, "We try a lot of things. I know that she does not do well with a lot of activity around her." On 2/1/17, at 3:27 p.m. RN-D explained R41 could become anxious over swallowing, and they tried fluids, cough syrup, deep breathing, and relaxing music. If the interventions did not work, they administered Ativan. R41's 1/17, medication administration record (MAR) was reviewed with RN-D. R41 was given Ativan seven times in the month, however, nursing documentation did not include information as to non-pharmacological interventions that had been attempted prior to its administration. RN-D verified the staff should have documented non-pharmacological interventions they had attempted. RN-E explained on 2/2/17, at 12:35 p.m. R41's anxiety had become even worse and approaches included offering reassurance, wheeling her in her wheelchair, music, aromatherapy, and puzzles, however lately had been refusing puzzles. A consultant pharmacist's (CP) recommendation	21540		

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21540	Continued From page 19 dated 12/29/16, requested the facility document which non-pharmacological interventions were tried prior to Ativan administration. The CP was interviewed on 2/2/17, at 1:30 p.m. She explained at the time of the review she would have been looking for more information regarding staffs' interventions utilized, and felt documentation was lacking in this regard in R41's medical record. The facility's 5/16, Psychoactive Medication and Unnecessary Medication Use Policy, indicated each resident's drug regimen was to be free from unnecessary drugs, which included any drug without adequate indications for use. hen used without adequate monitoring. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could update policies as needed. Appropriate staff could be trained to ensure individualized non-pharmacological interventions are developed and staff are utilizing the approaches prior to administering medication. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		