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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: FYYL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00973

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245312**

2.STATE VENDOR OR MEDICAID NO.
(L2) **255342200**

3. NAME AND ADDRESS OF FACILITY
(L3) **CASTLE RIDGE CARE CENTER**
(L4) **625 PRAIRIE CENTER DRIVE**
(L5) **EDEN PRAIRIE, MN** (L6) **55344**

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 **12/31/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **60** (L18)
13.Total Certified Beds **60** (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
	60			
(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:
Susanne Reuss, Unit Supervisor 03/18/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 03/18/2019 (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
05/01/1986
(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
12/31/2018
(L33)

DETERMINATION APPROVAL

Electronically delivered
March 18, 2019

Administrator
Castle Ridge Care Center
625 Prairie Center Drive
Eden Prairie, MN 55344

RE: Project Number S5312030

Dear Administrator:

On December 20, 2018, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 15, 2019. (42 CFR 488.417 (b))

This was based on the deficiencies cited by CMS for a Federal Monitoring Survey (FMS) completed on December 5, 2018, as well as health and life safety code surveys completed on November 14, 2018 and November 15, 2018. The most serious deficiencies at the time of the revisit were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 31, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 1, 2019, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance as of February 18, 2019.

As a result of the revisit findings, this Department recommended to the CMS Region V Office the following action related to the remedy previously imposed. The CMS Region V Office concurs and has authorized this Department to notify you of these action:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective February 15, 2019, be discontinued. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective February 15, 2019, is to be discontinued. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective February 15, 2019, is to be discontinued.

As CMS notified you in their letter of December 20, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 15, 2019.

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245312

March 18, 2019

Administrator
Castle Ridge Care Center
625 Prairie Center Drive
Eden Prairie, MN 55344

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective February 18, 2019 the above facility is certified for:

60 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 60 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Douglas Larson, Enforcement Specialist

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: FYYL

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Facility ID: 00973

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(L1) **245312**

2.STATE VENDOR OR MEDICAID NO.
(L2) **255342200**

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(L3) **CASTLE RIDGE CARE CENTER**
(L4) **625 PRAIRIE CENTER DRIVE**
(L5) **EDEN PRAIRIE, MN** (L6) **55344**

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 **11/15/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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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
	60			
(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:
Sandra Hick, HFE NE II — 12/21/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Douglas Larson, Enforcement Specialist — 12/27/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
05/01/1986
(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

Electronically delivered
November 28, 2018

Administrator
Castle Ridge Care Center
625 Prairie Center Drive
Eden Prairie, MN 55344

RE: Project Number S5312030

Dear Administrator:

On November 15, 2018, a standard survey was completed at your facility by the Minnesota Department(s) 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is December 25, 2018.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being

corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (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 (488.456(b)).

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 February 15, 2019 (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).

In addition, if substantial compliance with the regulations is not verified by May 15, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245312	A. BUILDING _____ B. WING _____	11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE RIDGE CARE CENTER	625 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 11/13/18 through 11/15/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 11/13/18 through 11/15/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.	F 561		12/18/18

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

Electronically Signed | 12/05/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245312	A. BUILDING _____ B. WING _____	11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE RIDGE CARE CENTER	625 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344

(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 561	Continued From page 1 §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the failed failed to accommodate 1 of 1 resident (R30) bathing preferences reviewed for choices. Findings included: R30's diagnoses included Parkinson's disease, seizure disorder and anxiety obtained from the annual Minimum Data Set (MDS) dated 9/20/18. The MDS also indicated R30 had intact cognition, required physical assistance of one person with bathing and R30 had indicated it was "Very important to choose between a tub bath, shower, bed bath or sponge bath."	F 561	This plan of correction constitutes this facilities written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of/or agreement with the deficiencies or conclusions contained in the department inspection report. On 11/15/18, the Clinical Coordinator (CC) for R30 reviewed bathing preferences with resident and his spouse. The nursing assistant assignment sheet was updated to reflect his preference to change the time for of his Sunday shower from the morning to 4pm in the afternoon due to R30 and his wife being busy attending	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245312	A. BUILDING _____ B. WING _____	11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE RIDGE CARE CENTER	625 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344

(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 561	Continued From page 2 On 11/13/18, at 1:51 p.m. when asked if he was able to choose how often he bathe, R30 and family member both stated he would like to bathe at least twice a week. Both stated when R30 moved into the facility this had been told R30 would get a bath twice a week but had not happened which was a little over a year. Family member stated it was important for R30 to get the second bath as R30 had experienced skin issues and both of them thought was probably related to R30's occasional incontinence. R30's care plan dated 5/10/18, indicated "This is my home now" and directed staff to allow resident to make choices in his daily care. R30's care plan for activities of daily living dated 5/31/18, identified R30 had a self-care performance deficit related to Parkinson's, seizure disorder, symptomatic epilepsy, malaise and muscle weakness. The care plan indicated R30 required assistance of one staff with bathing. On 11/14/18, at 4:47 p.m. nursing assistant (NA)-D stated when a resident was scheduled to get a shower the nurse always did check the skin and thought they documented it in the progress notes. NA-D reviewed the assignment sheet and verified R30 had two showers/bath days "Thursday AM and Sunday AM." On 11/15/18, at 11:23 a.m. registered nurse (RN)-C verified in the last three months R30 had not gotten a bath/shower on Sunday. RN-C stated the staff was supposed to write a note if R30 had refused or explaining why the shower was not completed and staff was to attempt to offer it. RN-C stated according to the documentation R30 was only getting one bath on Thursday which was not following the care plan as noted on the	F 561	worship service in the morning. On 12/3/18, the Resident Services Specialist (RSS) reviewed with R30 and spouse all of R30□s preferences to ensure satisfaction with current preferences. Changes have been recorded in R30□s care plan, assignment sheet and My Best Day (MBD). These preferences will be reviewed quarterly and as needed. The Nursing Assistants responsible for R30□s Sunday showers for the last three months have been educated on importance of following resident preference and proper documentation in Point of Care related to bathing. Staff on medical leave will be re-educated upon clearance and return to work. In order to identify other residents that have the potential to be affected by the deficient practice, RSS will complete an audit on all residents to ensure preferences are current and reflected in the care plan, nursing assistant assignment sheet, and MBD. Resident preferences will be reviewed and updated on an ongoing basis each quarter. Staff education on resident preferences and the MBD tool will be completed by 12/18/18. In order to monitor for ongoing compliance, bathing audits will be completed by RSS and Clinical Coordinators on 10% of the residents weekly. The results of these audits will be shared and discussed with the Quality Service Team (QST) on a monthly basis and the Quality Assurance and Assessment Committee (QAA) on a quarterly basis. The QST and QAA will review the audits to identify trends or patterns and to make recommendations	

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CASTLE RIDGE CARE CENTER	625 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344

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F 561	Continued From page 3 assignment sheet. On 11/15/18, at 11:32 a.m. the director of nursing (DON) stated all resident's preferences were to be followed and the preferences were to be reviewed on a quarterly basis to see if there was any changes. The DON verified R30 was scheduled to get a bath/shower on Thursdays and Sunday according to the assignment sheet. The DON further stated the staff was supposed to document why the bath/shower had not been done. On 11/15/18, at 2:29 p.m. the resident services director stated on admission staff usually completed an assessment and would find the resident preferences and this would be communicated to staff in the team sheet, closet care sheet and in the care plan. The resident services director further stated all resident showers were listed in the point of care (POC) tab to alert staff of the scheduled bath days.	F 561	for ongoing compliance.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	F 686		12/11/18

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F 686	Continued From page 4 new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 3 residents (R22 and R49) identified at risk for pressure ulcers (PU) received timely repositioning. Findings include: R49's admission record revealed R49 was admitted to the facility 4/10/13, with diagnosis including: Alzheimer's disease and chronic kidney disease stage three. A significant change Minimum Data Set (MDS) dated 10/24/18, indicated R49 required extensive assist of two with bed mobility, toileting and total assist of two with transfers. The MDS also indicated R49 was always incontinent of bladder and frequently incontinent of bowel. In addition, the MDS indicated R49 had severely impaired cognition. R49's pressure ulcer Care Area Assessment (CAA) dated 10/26/18, directed staff to provided extensive assist of one staff with turning and repositioning in bed and chair. In addition the CAA directed staff to provide extensive assist of two staff with major position changes such as boosting in bed. R49's care plan dated 10/17/18, identified R49 had impaired physical mobility and impaired range of motion related to Alzheimer's, postural kyphosis, weakness, debility and osteoporosis. The care plan indicated R49 needed assistance with bed mobility, transfers, Broda chair bound. The care plan indicated R49 required assistance to turn/reposition on rising, with check and changing incontinent brief, naps, at HS [bedtime]	F 686	This plan of correction constitutes this facilities written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of/or agreement with the deficiencies or conclusions contained in the department inspection report. The Facility does attempt to ensure that the resident receives care that is based on a comprehensive assessment and is consistent with professional standards. R49 is on Hospice. The resident has had wounds and pain re-assessed. There have been no adverse changes noted to the wounds as a result of the identified practices as reported by the MDH (Minnesota Department of Health) Survey Team. R49 treatment orders were modified and the nap/repositioning schedule for the resident was evaluated collaboratively with the Hospice staff and the facility staff. The Plan of Care for the resident has been reviewed, revised and updated. NA-A and NA -B will be re-educated. NA-B is on a Leave of Absence at the time the plan of correction is being submitted. R22 is on Hospice. The resident has had wounds and pain re-assessed. There have been no adverse changes noted to the wounds as a result of the identified practices as reported by the MDH (Minnesota Department of Health) Survey Team. R22 treatment orders were modified and the nap/repositioning	

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F 686	Continued From page 5 and more often as needed or requested in bed and Broda. In addition, R49's care plan dated 12/12/17, directed staff for toileting schedule staff was to check and change R49's brief on rising, after meals, HS, 1-2am, 4-5am, and prn. R49 was continually observed on 11/15/18, at 7:33 a.m., during morning cares. Nursing assistant (NA)-A called for assistance to transfer resident in the Broda chair and NA-B assisted. At 7:37 a.m., R49 was transferred from bed to the Broda chair via mechanical lift and was weighed at the same time. At 7:53 a.m., R49 was transported to the common area by the nursing station. During continuous observations on 11/15/18, from 7:37 a.m. through 10:45 a.m. (3 hours 8 minutes). R49 was observed to be sitting in a Broda chair. During the continuous observation period, there were no attempts made by staff to reposition R49. At 8:37 a.m. director of nursing (DON) transported R49 from the common area to the dining room for breakfast. At 10:45 a.m., NA-A and NA-B transferred R49 to bed with a mechanical lift. Both NA-A and NA-B confirmed R49 was not repositioned since they got her up in the Broda chair. R49's incontinent pad was observed to be dry. R49's coccyx was noted to be slightly reddened, and the skin appeared wrinkled with the wound dressing intact. During the continuous observation on 11/15/18, multiple staff including the administrator, director of nursing, registered nurse (RN)-A, RN-B, RN-C, RN-D, student nurse, and nursing assistants (NA-A, NA-B) walked past R49 however, never offered R49 repositioning.	F 686	schedule for the resident was evaluated collaboratively with the Hospice staff and the facility staff. The Plan of Care for the resident has been reviewed, revised and updated. NA-G has been re-educated. Systemic changes were made to the process that is followed in regards to Skin Care. The Nurse staffs that had cared for R22 and R49 have been and will be re-educated. Staff has been re-trained and educated in the care of skin, repositioning and the need to follow the plan of care from 11/26/2018 to 12/05/2018. The Clinical Coordinator (CC) and the Registered Nurse Clinical Administrator (RNCA) have reviewed the Skin Plan of care for all of the residents at risk for skin issues to ensure that appropriate interventions are identified. The Risk status of the residents was determined by a review of their most recent Braden Assessment. Staff has also had the additional consultation, review and education with the Regional Tena Manager for: incontinence management, peri-care hygiene, and skin protection. Follow up and review of the residents and staff was completed by the RDCA on 12/06/2018. The CC will audit 10% of the residents with skin issues each week to ensure that the Plan of Care is being followed. The audits will continue for a minimum of three months. The audits will be validated and reviewed by the RNCA each week to ensure that the identified interventions remain appropriate and are followed. The RNCA will report the audits to the	

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F 686	Continued From page 6 On 11/15/18, at 10:47 a.m., NA-A and NA-B stated R49 should have been laid down after breakfast. NA-B mentioned, R49's breakfast normally ran until 10:00 and they had seven residents that required assist to transfer. On 11/15/18, at 11:08 a.m., after reviewing R49's medical record, the DON confirmed R49 required assistance to turn/reposition. The DON stated, "My expectation is nursing staff to follow their care sheet. The care sheet should match the care plan. In her case I do not see she needs to be check and change every two hours but she should be repositioned and checked and change upon rising and after meals. Someone who has risk problem should be check more frequently." R22's pressure ulcer Care Area Assessment (CAA) dated 3/19/18, indicated R22 had a history of pressure ulcers, with no current pressure ulcers. R22's quarterly MDS dated 6/14/18, indicated R22 had one or more unhealed pressure ulcers. A quarterly MDS dated 9/13/18, indicated R22 continued to have one or more unhealed pressure ulcers. R22's care Plan dated 9/26/18, indicated resident had a history of pressure ulcer. During a review of the wound documentation in the medical record the following was revealed: -The Skin and Wound - Wound Assessment, dated 8/8/18, indicated R22 had a stage two pressure ulcer on the right heel that was acquired in the facility. The wound was described as 70% filled with slough and 30% granulation. -The Skin and Wound - Wound Assessment, dated 8/14/18, indicated the wound was first	F 686	Quality Service Team (QST) on a monthly basis and the Quality Assurance and Assessment Committee (QAA) quarterly basis. The QST and QAA will review the audits to identify trends or patterns and to make recommendations. The QST and QAA will also determine the need for ongoing audits after the initial period. The QST and QAA will ensure ongoing compliance with F686.	

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F 686	Continued From page 7	F 686		

identified on 6/1/18. The Skin and Wound - Wound Assessment, dated 9/19/18, indicated the wound was 100% slough filled indicating a worsening of the wound. An assessment, dated 10/10/18, indicated the wound was scabbed over.

-The Skin and Wound - Wound Assessment, dated 10/18/18, indicated the wound bed was 100% eschar.

-The Wound Assessment, dated 10/25/18, indicated the wound was resolved, but was still 100% eschar in the wound bed. A photo of the wound dated 10/25/18, identified a wound with a pink wound bed. R22's Physician Orders were reviewed and indicated the wound dressings were discontinued on 10/25/18.

During continuous observation on 11/15/18, from 7:29 a.m. to 8:48 a.m., R22 was observed lying in bed on her back with her feet covered. At 8:48 a.m. NA-G began morning cares and uncovered R22's legs and feet. There was a pillow on the mattress at the end of the bed. R22's right leg was crossed over her left leg. The right outer heel was resting on the left leg. R22's left leg was not elevated off the bed. R22's left heel was resting on the mattress directly. The right heel had a wound on the outer edge that was 100% eschar with dry skin around the outer edges. The left heel had an dark pink area of approximately 2 cm. At 8:56 RN-C assessed the wound and stated there was a wound on the right heel and the left heel was red and non blanchable. RN-C stated the procedure was to update hospice and the primary care provider.

On 11/15/18, at 2:06 p.m., during interview, the DON stated protective boots had been

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F 686	Continued From page 8 considered in August 2018, but were determined to be a risk for R22 because of her ability to transfer herself. The DON added R22 had declined recently, and the reoccurring wounds were not a surprise. When asked if R22 had been re-assessed after the decline to reconsider heel protecting boots, DON stated it was possible a re-assessment was indicated and could have been discussed at an interdisciplinary team meeting but it had not happened yet. The facility policy and procedure titled SKIN INTEGRITY MANAGEMENT POLICY-MINNESOTA dated September 2018, identified, "Based upon the findings of the clinical assessment in partnership with the resident and/ or family input, a care plan will be developed or modified to reflect alterations in interventions and implementation of new interventions specific to the resident. The care planned interventions will be communicated to the appropriate staff via the nursing assistant assignment sheet or My Best Day and/or through report ... 2. Establish an individualized turning and repositioning schedule if the resident is immobile ... The care plan is to be evaluated and revised based on response, outcomes, and needs of the resident."	F 686		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		12/11/18

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F 761	Continued From page 9 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 4 medication/treatment carts which held biological's and medications (anti-depressants, anti-psychotropic, blood pressure medication, insulin, supplements/vitamins among other prescribed medication) were locked to prevent staff, residents and visitors from gaining access. Findings include: On 11/13/18, at 7:02 p.m. the key lock to the nurse treatment cart was fully extended in the unlocked position on the B side. The nurse treatment cart was parked across from the nursing station on the B side hallway. At the beginning of the observation one resident was seated at the desk close to the unlocked treatment cart. -At 7:09 p.m. nursing assistant (NA)-E went past	F 761	This plan of correction constitutes this facilities written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of/or agreement with the deficiencies or conclusions contained in the department inspection report. The facility does attempt to ensure that drugs and biologicals used in the facility are managed in accordance with acceptable professional standards. There were no residents identified. There have been no adverse changes noted to the residents as a result of the identified practices as reported by the MDH (Minnesota Department of Health) Survey Team. The Nurse that was in charge of the A cart on the AM shift 11/15/2018 was re-educated. The Nurse that was in	

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F 761	Continued From page 10 the unlocked nurse treatment cart. -At 7:10 p.m. NA-E was observed ambulating down the hallway with R4 and past the unlocked cart. -At 7:11 p.m. R10 went past the unlocked nurse treatment cart. -At 7:12 the trained medication aide (TMA)-A was observed go past the cart and went to the nursing station when surveyor intervened and asked her to lock the cart. TMA-A verified the nurse treatment cart was unlocked and was used to store insulin and other prescription treatments for residents. TMA-A stated the cart was supposed to be locked at all times when staff was not at the cart. On 11/15/18, at 7:54 a.m. during a random observation the medication cart was observed unlocked outside room 13 in the A side unit. During the observation licensed practical nurse (LPN)-A was observed walking away from the medication cart and unit towards the nursing station. -At 7:55 a.m. LPN-A returned to the medication cart and locked the cart as surveyor stood there. On 11/15/18, at 11:32 a.m. the director of nursing (DON) stated medications and treatment carts were to be locked at all times when not in use.	F 761	charge of the B cart on the PM shift of 11/13/2018 was re-educated. Systemic changes were made to the process that is followed in regards to Medication Administration. Staff has been re-trained and educated on the proper protocols for the distribution of the medications from 11/26/2018 to 12/05/2018. Staff has also had the additional consultation, review, and education with the Merwin□s Consultant Pharmacist. The Medication Treatment Cart and locking device were changed. Follow up and review of the residents and staff was completed by the RDCA on 12/06/2018. The CC will perform two medication cart audits each week on each shift to ensure that the Medication Administration policy is being followed. The audits will continue for a minimum of three months. The audits will be validated and reviewed by the RNCA each week to ensure that the staff is following the policy. The RNCA will report the audits to the Quality Service Team (QST) on a monthly basis and the Quality Assurance and Assessment Committee (QAA) quarterly basis. The QST and QAA will review the audits to identify trends or patterns and to make recommendations. The QST and QAA will also determine the need for ongoing audits after the initial period. The QST and QAA will ensure ongoing compliance with F761.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		12/11/18

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F 880	Continued From page 11 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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F 880	Continued From page 12 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene and glove use for 2 of 4 residents (R2, R19) reviewed for pressure ulcers. In addition, the facility failed to ensure appropriate hand hygiene for 3 of 5 residents (R13, R18, R51) observed during medication administration. Findings include: On 11/14/18, from 12:57 p.m. to 1:02 p.m. nursing assistant (NA)-C was observed providing	F 880	This plan of correction constitutes this facilities written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of/or agreement with the deficiencies or conclusions contained in the department inspection report. The Facility does attempt to maintain an infection prevention and control program. R2 is on Hospice. The resident has been evaluated for signs and symptoms (s/s) of infection. The resident has had wounds	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 13 R2 with pericares. During the observation, NA-C approached R2, and stated he was going to change the incontinent pad. He unfastened the pad, then told R2 he was going to turn her to the right side. NA-C then completed front pericare with a wet wipe and then used three wet wipes to wipe stool off R2's bottom. After NA-C finished, he pulled the soiled pad and tossed it in the garbage can. Without performing hand hygiene or changing gloves, NA-C reached out for a clean pad on the bedside dresser, opened it tucked under R2's body then fastened it on both sides. At 12:59 a.m. still wearing the same gloves, NA-C was observed to touch R2's body, linen and other clean clothing. At 1:00 p.m. NA-C removed gloves and without washing hands NA-C pulled the privacy curtain open, used the bed remote to lower the bed, gathered the trash then went to the bathroom and washed his hands. On 11/14/18, at 1:03 p.m. NA-C stated he was supposed to change gloves and wash hands after pericare and before proceeding with other cares. On 11/7/18, at 2:34 p.m. registered nurse (RN)-C stated staff were supposed to remove gloves, wash hands then re-apply another pair of gloves after doing pericare. On 11/15/18, at 11:32 a.m. the director of nursing (DON) stated staff were supposed to wash their hands with glove changes, when hands/gloves were soiled and in between dirty and clean. The facility Infection Prevention and Control Manual dated 2017, instructed staff "Hand hygiene must be performed after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are	F 880	and pain re-assessed. There have been no adverse changes noted to the resident as a result of the identified practices as reported by the MDH (Minnesota Department of Health) Survey Team. The resident does not display any signs or symptoms of infection. The room of the resident had a deep clean performed by the Housekeeping Department. R19 is on Hospice. The resident has been evaluated for s/s of infection. The resident has had wounds and pain re-assessed. There have been no adverse changes noted to the resident as a result of the identified practices as reported by the MDH (Minnesota Department of Health) Survey Team. The resident does not display any signs or symptoms of infection. The room of the resident had a deep clean performed by the Housekeeping Department. R18, R13 and R51 have all been assessed for s/s of infection. The residents have no signs or symptoms of infection at this time. There have been no adverse changes noted to the resident as a result of the identified practices as reported by the MDH (Minnesota Department of Health) Survey Team. The NAR who cared for R2 NA-C was re-educated by the RDCA on 12/03/2018. The NAR who cared for R19 NA-F was re-educated by the CC on 12/04/2018. The Nurse, RN-A, who cared for R18, R13 and R51, was re-educated by the RDCA at the time of the survey. The RNCA reviewed her medication delivery practices on 12/05/2018.	

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	245312	A. BUILDING _____ B. WING _____	11/15/2018

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F 880	Continued From page 14 worn; immediately after gloves are removed; and when otherwise indicated to avoid transfer of microorganisms to other residents, personnel, equipment and the environment. In addition, the policy directed staff to perform hand hygiene at the following times: Before and after direct resident care, before and after entering isolation precaution settings, before and after touching wounds of any kind, before and after coming in contact with a resident's intact skin (e.g., when taking a pulse or blood pressure, after handling soiled dressings and after caring for a resident with an active infection. R19 was observed lying in bed on 11/15/18, at 8:15 a.m. NA-F and student nurse (SN) entered the room and donned gloves. NA-F unfastened R19's pad, put cleanser on two wipes and completed front pericare with the two wipes and tossed the used wipes in the wastebasket. NA-F then took two new wipes and completed front pericare and pushed the two used wipes into the pad. The SN assisted NA-F in turning R19 to right side, pulled out wipes and pad, placed wipes and pad in wastebasket, and then took two new wipes with cleanser completed wiping R19's bottom, tossed the wipes in the wastebasket, took out two more new wipes and wiped R19's bottom and tossed in wastebasket. Without removing dirty gloves NA-F placed a clean pad under R19 and SN helped NA-F roll R19 to back. NA-F pulled up pad and fastened tabs. Without removing dirty gloves NA-F pulled R19's nightgown down, picked up pillow from foot of bed and placed to resident's right side, placed an additional pillow under R19's legs, lowered the bed with the remote, adjusted the bedspread, hooked call light on top of blanket, and covered R19 up with two additional blankets. NA-F then removed the dirty	F 880	Systemic changes were made to the process that is followed in regards to Infection Control. Staff has been re-trained and educated in the proper protocols for the delivery of proper peri cares, hand hygiene and medication distribution from 11/26/2018 to 12/05/2018. Staff has also had the additional consultation, review, and education with the Regional Tena Manager for: incontinence management, peri-care hygiene and skin protection. Follow up and review of the residents and staff was completed by the RDCA on 12/06/2018. The CC will audit hand hygiene, peri-cares, and infection control on all three shifts to ensure that the Infection Control policy is being followed. The audits will continue for a minimum of three months. The audits will be validated and reviewed by the RNCA each week to ensure that the staff is following the policy and that the delivery of care is appropriate. The RNCA will report the audits to the Quality Service Team (QST) on a monthly basis and the Quality Assurance and Assessment Committee (QAA) quarterly basis. The QST and QAA will review the audits to identify trends or patterns and to make recommendations. The QST and QAA will also determine the need for ongoing audits after the initial period. The QST and QAA will ensure F880.	

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F 880	Continued From page 15	F 880		

gloves and tossed in a wastebasket. NA-F confirmed he had not removed his dirty gloves before applying R19's clean pad, touched nightgown, pillows, bed remote, bedspread, call light and blankets.

On 11/15/18, at 12:25 p.m. DON stated hand hygiene should be performed by staff after completion of pericare prior to contact of clean items. DON stated hand hygiene included removal of gloves then staff either washing their hands or hand sanitization.

Medication Administration:
On 11/15/18, at 8:32 a.m. RN-A was observed opening medication cart drawers and pulled out medication cards and bottles of medication from the drawer and placed on top of the cart. RN-A then picked up medication card for R18's medication Carbamazepine punched out two tabs into her right fingers and placed the two tablets into the medication cup directly with her fingers. RN-A then picked up a pen with her right hand and wrote on paper on top of the cart. RN-A then opened up the cart drawer and pulled out some medications in a bag, card and bottles and placed on top of cart. RN-A then took one multi vitamin out of the bottle with her fingers and placed in medication cup with her fingers, and then picked up pen and wrote on paper on top of cart. RN-A then opened up the cart drawer and pulled more medications out and then took two tablets of Tylenol out of bottle from left fingers to right fingers and placed into medication cup. RN-A administered medications to R18.

On 11/15/18, at 11:51 a.m. RN-A was observed opening up medication cart drawer from the

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F 880	Continued From page 16	F 880		

medication cart and pulling out medication cards for R13. RN-A then placed Keppra tab from medication card with right fingers and placed into medication cup with her fingers. RN-A then took two Senna S tabs into her left fingers and placed into medication cup. RN-A then removed prednisone tab with right hand and placed into medication cup with her fingers. RN-A wrote in the narcotic book with a pen, then administered medications to R51. RN-A opened up the medication cart drawers and pulled out some medication cards and bottles and a box of medications. RN-A then took Gabapentin capsule into her right fingers and placed into medication cup. RN-D then opened up the multi vitamin bottle for R51 and took out a vitamin and placed into the cup with her right fingers. RN-D then picked up a marker and wrote on a cup, poured glass of water and administered medications to R51.

On 11/15/18, at 12:22 p.m. DON stated she expected the residents' pills to not be touched with staff hands or contaminated during distribution.

Policy provided by the facility Medication Administration Policy modified dated December 2017, indicated, "To ensure safe, effective and timely drug therapy..." and indicated medications were to be administered in accordance with standard nursing practice.

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on November 14, 2018. At the time of this survey, Castle Ridge Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/05/2018

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

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K 000	Continued From page 1 REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Castle Ridge Care Center is a 1-story building with no basement. The building was constructed at three different times. The original building was constructed in 1983 and was determined to be of Type V (111) construction. In 1987, an addition was constructed and was determined to be of Type V (111) construction. In 1997, an addition was constructed and was determined to be Type V (111) construction. Because the original building and the two additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The facility is fully protected throughout an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 60 beds and had a census of 57 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (9.7.5, 9.7.7, 9.7.8, and NFPA 25) This deficient practice could affect the safety of all (56) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include:	K 353	On 11/15/18, the Environmental Services Director removed all items stored within 18 inches of the sprinkler head height. The Environmental Services Director will audit monthly all areas of the facility for improper high storage. The audits will be reviewed by the Quality Assessment and	11/15/18

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K 353	Continued From page 3 On facility tour between 1:00 PM and 4:00 PM on 11/14/2018, observations and staff interview revealed the following: During walk-through of the facility observed that Rm #31 - high storage in close proximity to a sprinkler head This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 353	Assurance Committee quarterly for ongoing compliance.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.3.5.12, NFPA 10) This deficient practice could affect the safety of all (56) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 1:00 PM and 4:00 PM on 11/14/2018, observations and staff interview revealed the following: During walk-through of the facility observed that Rm #20 (Kitchen) - direct access to fire extinguisher cabinet was obstructed	K 355	On 11/14/18, the Environmental Services Director cleared the obstruction in front of the fire extinguisher in Room #20. Education has been completed with the culinary department regarding the importance of having direct access to fire extinguishers at all times. Ongoing education regarding direct access to all fire extinguishers will be completed at fire drills. The Environmental Services Director will audit direct access to fire extinguishers on a monthly basis. The results of these audits will be reviewed by the Quality Assurance Committee quarterly for ongoing compliance.	11/19/18

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K 355	Continued From page 4 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 355		
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (NFPA 54, 19.5.1.1, 9.1.1, 9.1.2) This deficient practice could affect the safety of all (56) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 1:00 PM and 4:00 PM on 11/14/2018, observations and staff interview revealed the following: During walk-through of the facility observed at the B-Wing Smoke Barrier - above the ceiling tile that an electrical box cover connected to conduit was separated from the junction box	K 511	On 11/19/18, the Environmental Services Director reconnected the electrical box cover in the proper location on the junction box observed at the B-Wing Smoke Barrier above the ceiling tile. The Environmental Services Director will ensure electrical boxes are properly covered.	11/19/18

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K 511	Continued From page 5 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 511		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.5.2.1, 9.2, NFPA 90A - Annex B.2.2) This deficient practice could affect the safety of all (56) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 1:00 PM and 4:00 PM on 11/14/2018, observation and documentation reviewed revealed the following: Documentation review indicated all fire dampers were tested in Feb 2018 - testing report identified all devices failed. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 521	On 12/20/18, the Environmental Services Director signed a contract with NAC Mechanical & Electrical Services to get the fire dampers replaced. The parts needed for the replacement have a delivery time frame of four weeks. The replacement will be completed by NAC Mechanical & Electrical Services when the parts arrive. The Environmental Services Director will document the replacement when complete and future testing will be done at the required intervals.	2/18/19
K 712	Fire Drills	K 712		12/28/18

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K 712 SS=D	Continued From page 6 CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.7.1.4 through 19.7.1.7) This deficient practice could affect the safety of all (56) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 1:00 PM and 4:00 PM on 11/14/2018, observation and documentation reviewed revealed the following: Documentation review indicated that fire drills for 3rd shift had common time-stamps for 1st and 3rd quarter and for 2nd and 4th quarter. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 712	The Environmental Services Director will conduct fire drills at random times and that only two of the four drill times in the same shift are within 1¿ hours of each other. This corrective action will begin with the December fire drills for 2018. The Environmental Services Director will ensure that this practice continues for future fire drills.	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101	K 920		12/5/18

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K 920	Continued From page 7 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5) This deficient practice could affect the safety of all (56) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 1:00 PM and 4:00 PM on 11/14/2018, observations and staff interview revealed the following:	K 920	The Environmental Service Director will work with an electrician to install an additional receptacle in Room #3. Power strips were removed from Room #29 (laundry), Room #C16 (chapel), staff lounge, and Room #9 (beauty shop). Education will be completed with all staff during fire drills. The Environmental Services Director will ensure that no appliances are plugged into power strips and that no combinations of power strips and extension cords exist in the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245312	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/14/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE RIDGE CARE CENTER	**625 PRAIRIE CENTER DRIVE** **EDEN PRAIRIE, MN 55344**

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K 920	Continued From page 8 During walk-through of the facility observed the following: Rm # 3 (Med Rm) Refrigerators connected to power strip; Rm #29 (Laundry) - Refrigerator connected to power strip; Rm #C16 (Chapel) - Power-strips daisy-chained together; Staff Lounge - Toaster connected to power strip; Rm # 9 (Beauty Shop) daisy-chaining of 2 extension cords connected to a power strip This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 920		
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.	K 923		12/4/18

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K 923	Continued From page 9 A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (5.1.3.3.2 and 5.1.3.3.3) This deficient practice could affect the safety of all (56) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 1:00 PM and 4:00 PM on 11/14/2018, observations and staff interview the following: During walk-through of the facility observed that Rm #A4 (O2 Storage) did not signage in the room to identify separation of full / empty cylinders This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 923	On 12/4/18, proper signage was added to Room #A4 to identify separation of full and empty oxygen cylinders. The Director of Nursing will ensure ongoing compliance.	

Electronically delivered
November 28, 2018

Administrator
Castle Ridge Care Center
625 Prairie Center Drive
Eden Prairie, MN 55344

Re: State Nursing Home Licensing Orders - Project Number S5312030

Dear Administrator:

The above facility was surveyed on November 13, 2018 through November 15, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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:

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

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

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

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00973	A. BUILDING: _____ B. WING _____	11/15/2018

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CASTLE RIDGE CARE CENTER	625 PRAIRIE CENTER DRIVE EDEN PRAIRIE, MN 55344

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/13/18, through 11/15/18, 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.	2 000		

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

Electronically Signed | 12/05/18

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2 000	Continued From page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop	2 900		12/11/18

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2 900	Continued From page 2 pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 3 residents (R22 and R49) identified at risk for pressure ulcers (PU) received timely repositioning. Findings include: R49's admission record revealed R49 was admitted to the facility 4/10/13, with diagnosis including: Alzheimer's disease and chronic kidney disease stage three. A significant change Minimum Data Set (MDS) dated 10/24/18, indicated R49 required extensive assist of two with bed mobility, toileting and total assist of two with transfers. The MDS also indicated R49 was always incontinent of bladder and frequently incontinent of bowel. In addition, the MDS indicated R49 had severely impaired cognition. R49's pressure ulcer Care Area Assessment (CAA) dated 10/26/18, directed staff to provided extensive assist of one staff with turning and repositioning in bed and chair. In addition the CAA directed staff to provide extensive assist of two staff with major position changes such as boosting in bed. R49's care plan dated 10/17/18, identified R49	2 900	Corrected	

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2 900	Continued From page 3 had impaired physical mobility and impaired range of motion related to Alzheimer's, postural kyphosis, weakness, debility and osteoporosis. The care plan indicated R49 needed assistance with bed mobility, transfers, Broda chair bound. The care plan indicated R49 required assistance to turn/reposition on rising, with check and changing incontinent brief, naps, at HS [bedtime] and more often as needed or requested in bed and Broda. In addition, R49's care plan dated 12/12/17, directed staff for toileting schedule staff was to check and change R49's brief on rising, after meals, HS, 1-2am, 4-5am, and prn. R49 was continually observed on 11/15/18, at 7:33 a.m., during morning cares. Nursing assistant (NA)-A called for assistance to transfer resident in the Broda chair and NA-B assisted. At 7:37 a.m., R49 was transferred from bed to the Broda chair via mechanical lift and was weighed at the same time. At 7:53 a.m., R49 was transported to the common area by the nursing station. During continuous observations on 11/15/18, from 7:37 a.m. through 10:45 a.m. (3 hours 8 minutes). R49 was observed to be sitting in a Broda chair. During the continuous observation period, there were no attempts made by staff to reposition R49. At 8:37 a.m. director of nursing (DON) transported R49 from the common area to the dining room for breakfast. At 10:45 a.m., NA-A and NA-B transferred R49 to bed with a mechanical lift. Both NA-A and NA-B confirmed R49 was not repositioned since they got her up in the Broda chair. R49's incontinent pad was observed to be dry. R49's coccyx was noted to be slightly reddened, and the skin appeared wrinkled with the wound dressing intact.	2 900		

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2 900	Continued From page 4 During the continuous observation on 11/15/18, multiple staff including the administrator, director of nursing, registered nurse (RN)-A, RN-B, RN-C, RN-D, student nurse, and nursing assistants (NA-A, NA-B) walked past R49 however, never offered R49 repositioning. On 11/15/18, at 10:47 a.m., NA-A and NA-B stated R49 should have been laid down after breakfast. NA-B mentioned, R49's breakfast normally ran until 10:00 and they had seven residents that required assist to transfer. On 11/15/18, at 11:08 a.m., after reviewing R49's medical record, the DON confirmed R49 required assistance to turn/reposition. The DON stated, "My expectation is nursing staff to follow their care sheet. The care sheet should match the care plan. In her case I do not see she needs to be check and change every two hours but she should be repositioned and checked and change upon rising and after meals. Someone who has risk problem should be check more frequently." R22's pressure ulcer Care Area Assessment (CAA) dated 3/19/18, indicated R22 had a history of pressure ulcers, with no current pressure ulcers. R22's quarterly MDS dated 6/14/18, indicated R22 had one or more unhealed pressure ulcers. A quarterly MDS dated 9/13/18, indicated R22 continued to have one or more unhealed pressure ulcers. R22's care Plan dated 9/26/18, indicated resident had a history of pressure ulcer. During a review of the wound documentation in the medical record the following was revealed: -The Skin and Wound - Wound Assessment, dated 8/8/18, indicated R22 had a stage two	2 900		

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2 900	Continued From page 5 pressure ulcer on the right heel that was acquired in the facility. The wound was described as 70% filled with slough and 30% granulation. -The Skin and Wound - Wound Assessment, dated 8/14/18, indicated the wound was first identified on 6/1/18. The Skin and Wound - Wound Assessment, dated 9/19/18, indicated the wound was 100% slough filled indicating a worsening of the wound. An assessment, dated 10/10/18, indicated the wound was scabbed over. -The Skin and Wound - Wound Assessment, dated 10/18/18, indicated the wound bed was 100% eschar. -The Wound Assessment, dated 10/25/18, indicated the wound was resolved, but was still 100% eschar in the wound bed. A photo of the wound dated 10/25/18, identified a wound with a pink wound bed. R22's Physician Orders were reviewed and indicated the wound dressings were discontinued on 10/25/18. During continuous observation on 11/15/18, from 7:29 a.m. to 8:48 a.m., R22 was observed lying in bed on her back with her feet covered. At 8:48 a.m. NA-G began morning cares and uncovered R22's legs and feet. There was a pillow on the mattress at the end of the bed. R22's right leg was crossed over her left leg. The right outer heel was resting on the left leg. R22's left leg was not elevated off the bed. R22's left heel was resting on the mattress directly. The right heel had a wound on the outer edge that was 100% eschar with dry skin around the outer edges. The left heel had an dark pink area of approximately 2 cm. At 8:56 RN-C assessed the wound and stated there was a wound on the right heel and the left heel was red and non blanchable. RN-C	2 900		

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2 900	Continued From page 6 stated the procedure was to update hospice and the primary care provider. On 11/15/18, at 2:06 p.m., during interview, the DON stated protective boots had been considered in August 2018, but were determined to be a risk for R22 because of her ability to transfer herself. The DON added R22 had declined recently, and the reoccurring wounds were not a surprise. When asked if R22 had been re-assessed after the decline to reconsider heel protecting boots, DON stated it was possible a re-assessment was indicated and could have been discussed at an interdisciplinary team meeting but it had not happened yet. The facility policy and procedure titled SKIN INTEGRITY MANAGEMENT POLICY-MINNESOTA dated September 2018, identified, "Based upon the findings of the clinical assessment in partnership with the resident and/ or family input, a care plan will be developed or modified to reflect alterations in interventions and implementation of new interventions specific to the resident. The care planned interventions will be communicated to the appropriate staff via the nursing assistant assignment sheet or My Best Day and/or through report ... 2. Establish an individualized turning and repositioning schedule if the resident is immobile ... The care plan is to be evaluated and revised based on response, outcomes, and needs of the resident." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of	2 900		

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2 900	Continued From page 7 pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 900		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 3 residents (R22 and R49) identified at risk for pressure ulcers (PU) received timely repositioning. Findings include: R49's admission record revealed R49 was admitted to the facility 4/10/13, with diagnosis including: Alzheimer's disease and chronic kidney disease stage three. A significant change Minimum Data Set (MDS) dated 10/24/18, indicated R49 required extensive assist of two with bed mobility, toileting and total	2 905	Corrected	12/11/18

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2 905	Continued From page 8	2 905		

assist of two with transfers. The MDS also indicated R49 was always incontinent of bladder and frequently incontinent of bowel. In addition, the MDS indicated R49 had severely impaired cognition. R49's pressure ulcer Care Area Assessment (CAA) dated 10/26/18, directed staff to provided extensive assist of one staff with turning and repositioning in bed and chair. In addition the CAA directed staff to provide extensive assist of two staff with major position changes such as boosting in bed.

R49's care plan dated 10/17/18, identified R49 had impaired physical mobility and impaired range of motion related to Alzheimer's, postural kyphosis, weakness, debility and osteoporosis. The care plan indicated R49 needed assistance with bed mobility, transfers, Broda chair bound. The care plan indicated R49 required assistance to turn/reposition on rising, with check and changing incontinent brief, naps, at HS [bedtime] and more often as needed or requested in bed and Broda. In addition, R49's care plan dated 12/12/17, directed staff for toileting schedule staff was to check and change R49's brief on rising, after meals, HS, 1-2am, 4-5am, and prn.

R49 was continually observed on 11/15/18, at 7:33 a.m., during morning cares. Nursing assistant (NA)-A called for assistance to transfer resident in the Broda chair and NA-B assisted. At 7:37 a.m., R49 was transferred from bed to the Broda chair via mechanical lift and was weighed at the same time. At 7:53 a.m., R49 was transported to the common area by the nursing station.

During continuous observations on 11/15/18, from 7:37 a.m. through 10:45 a.m. (3 hours 8 minutes). R49 was observed to be sitting in a Broda chair.

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2 905	Continued From page 9 During the continuous observation period, there were no attempts made by staff to reposition R49. At 8:37 a.m. director of nursing (DON) transported R49 from the common area to the dining room for breakfast. At 10:45 a.m., NA-A and NA-B transferred R49 to bed with a mechanical lift. Both NA-A and NA-B confirmed R49 was not repositioned since they got her up in the Broda chair. R49's incontinent pad was observed to be dry. R49's coccyx was noted to be slightly reddened, and the skin appeared wrinkled with the wound dressing intact. During the continuous observation on 11/15/18, multiple staff including the administrator, director of nursing, registered nurse (RN)-A, RN-B, RN-C, RN-D, student nurse, and nursing assistants (NA-A, NA-B) walked past R49 however, never offered R49 repositioning. On 11/15/18, at 10:47 a.m., NA-A and NA-B stated R49 should have been laid down after breakfast. NA-B mentioned, R49's breakfast normally ran until 10:00 and they had seven residents that required assist to transfer. On 11/15/18, at 11:08 a.m., after reviewing R49's medical record, the DON confirmed R49 required assistance to turn/reposition. The DON stated, "My expectation is nursing staff to follow their care sheet. The care sheet should match the care plan. In her case I do not see she needs to be check and change every two hours but she should be repositioned and checked and change upon rising and after meals. Someone who has risk problem should be check more frequently." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review	2 905		

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2 905	Continued From page 10 all residents at risk for positioning need to assure they are receiving the necessary treatment/services. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene and glove use for 2 of 4 residents (R2, R19) reviewed for pressure ulcers. In addition, the facility failed to ensure appropriate hand hygiene for 3 of 5 residents (R13, R18, R51) observed during medication administration. Findings include: On 11/14/18, from 12:57 p.m. to 1:02 p.m. nursing assistant (NA)-C was observed providing R2 with pericares. During the observation, NA-C approached R2, and stated he was going to change the incontinent pad. He unfastened the pad, then told R2 he was going to turn her to the right side. NA-C then completed front pericare with a wet wipe and then used three wet wipes to	21375	Corrected	12/11/18

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21375	Continued From page 11	21375		

wipe stool off R2's bottom. After NA-C finished, he pulled the soiled pad and tossed it in the garbage can. Without performing hand hygiene or changing gloves, NA-C reached out for a clean pad on the bedside dresser, opened it tucked under R2's body then fastened it on both sides. At 12:59 a.m. still wearing the same gloves, NA-C was observed to touch R2's body, linen and other clean clothing. At 1:00 p.m. NA-C removed gloves and without washing hands NA-C pulled the privacy curtain open, used the bed remote to lower the bed, gathered the trash then went to the bathroom and washed his hands.

On 11/14/18, at 1:03 p.m. NA-C stated he was supposed to change gloves and wash hands after pericare and before proceeding with other cares.

On 11/7/18, at 2:34 p.m. registered nurse (RN)-C stated staff were supposed to remove gloves, wash hands then re-apply another pair of gloves after doing pericare.

On 11/15/18, at 11:32 a.m. the director of nursing (DON) stated staff were supposed to wash their hands with glove changes, when hands/gloves were soiled and in between dirty and clean.

The facility Infection Prevention and Control Manual dated 2017, instructed staff "Hand hygiene must be performed after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn; immediately after gloves are removed; and when otherwise indicated to avoid transfer of microorganisms to other residents, personnel, equipment and the environment. In addition, the policy directed staff to perform hand hygiene at the following times: Before and after direct resident care, before and after entering isolation

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21375	Continued From page 12 precaution settings, before and after touching wounds of any kind, before and after coming in contact with a resident's intact skin (e.g., when taking a pulse or blood pressure, after handling soiled dressings and after caring for a resident with an active infection. R19 was observed lying in bed on 11/15/18, at 8:15 a.m. NA-F and student nurse (SN) entered the room and donned gloves. NA-F unfastened R19's pad, put cleanser on two wipes and completed front pericare with the two wipes and tossed the used wipes in the wastebasket. NA-F then took two new wipes and completed front pericare and pushed the two used wipes into the pad. The SN assisted NA-F in turning R19 to right side, pulled out wipes and pad, placed wipes and pad in wastebasket, and then took two new wipes with cleanser completed wiping R19's bottom, tossed the wipes in the wastebasket, took out two more new wipes and wiped R19's bottom and tossed in wastebasket. Without removing dirty gloves NA-F placed a clean pad under R19 and SN helped NA-F roll R19 to back. NA-F pulled up pad and fastened tabs. Without removing dirty gloves NA-F pulled R19's nightgown down, picked up pillow from foot of bed and placed to resident's right side, placed an additional pillow under R19's legs, lowered the bed with the remote, adjusted the bedspread, hooked call light on top of blanket, and covered R19 up with two additional blankets. NA-F then removed the dirty gloves and tossed in a wastebasket. NA-F confirmed he had not removed his dirty gloves before applying R19's clean pad, touched nightgown, pillows, bed remote, bedspread, call light and blankets. On 11/15/18, at 12:25 p.m. DON stated hand hygiene should be performed by staff after	21375		

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21375	Continued From page 13 completion of pericare prior to contact of clean items. DON stated hand hygiene included removal of gloves then staff either washing their hands or hand sanitization. Medication Administration: On 11/15/18, at 8:32 a.m. RN-A was observed opening medication cart drawers and pulled out medication cards and bottles of medication from the drawer and placed on top of the cart. RN-A then picked up medication card for R18's medication Carbamazepine punched out two tabs into her right fingers and placed the two tablets into the medication cup directly with her fingers. RN-A then picked up a pen with her right hand and wrote on paper on top of the cart. RN-A then opened up the cart drawer and pulled out some medications in a bag, card and bottles and placed on top of cart. RN-A then took one multi vitamin out of the bottle with her fingers and placed in medication cup with her fingers, and then picked up pen and wrote on paper on top of cart. RN-A then opened up the cart drawer and pulled more medications out and then took two tablets of Tylenol out of bottle from left fingers to right fingers and placed into medication cup. RN-A administered medications to R18. On 11/15/18, at 11:51 a.m. RN-A was observed opening up medication cart drawer from the medication cart and pulling out medication cards for R13. RN-A then placed Keppra tab from medication card with right fingers and placed into medication cup with her fingers. RN-A then took two Senna S tabs into her left fingers and placed into medication cup. RN-A then removed prednisone tab with right hand and placed into medication cup with her fingers. RN-A wrote in the narcotic book with a pen, then administered	21375		

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21375	Continued From page 14 medications to R51. RN-A opened up the medication cart drawers and pulled out some medication cards and bottles and a box of medications. RN-A then took Gabapentin capsule into her right fingers and placed into medication cup. RN-D then opened up the multi vitamin bottle for R51 and took out a vitamin and placed into the cup with her right fingers. RN-D then picked up a marker and wrote on a cup, poured glass of water and administered medications to R51. On 11/15/18, at 12:22 p.m. DON stated she expected the residents' pills to not be touched with staff hands or contaminated during distribution. Policy provided by the facility Medication Administration Policy modified dated December 2017, indicated, "To ensure safe, effective and timely drug therapy..." and indicated medications were to be administered in accordance with standard nursing practice. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review infection control practices during personal cares and educate staff. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented in order to reduce the risk of infection. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage	21610		12/11/18

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21610	Continued From page 15 Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 4 medication/treatment carts which held biological's and medications (anti-depressants, anti-psychotropic, blood pressure medication, insulin, supplements/vitamins among other prescribed medication) were locked to prevent staff, residents and visitors from gaining access. Findings include: On 11/13/18, at 7:02 p.m. the key lock to the nurse treatment cart was fully extended in the unlocked position on the B side. The nurse treatment cart was parked across from the nursing station on the B side hallway. At the beginning of the observation one resident was seated at the desk close to the unlocked treatment cart. -At 7:09 p.m. nursing assistant (NA)-E went past the unlocked nurse treatment cart. -At 7:10 p.m. NA-E was observed ambulating down the hallway with R4 and past the unlocked cart. -At 7:11 p.m. R10 went past the unlocked nurse treatment cart. -At 7:12 the trained medication aide (TMA)-A was observed go past the cart and went to the nursing station when surveyor intervened and asked her to lock the cart. TMA-A verified the nurse treatment cart was unlocked and was used to store insulin and other prescription treatments for	21610	Corrected	

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21610	Continued From page 16 residents. TMA-A stated the cart was supposed to be locked at all times when staff was not at the cart. On 11/15/18, at 7:54 a.m. during a random observation the medication cart was observed unlocked outside room 13 in the A side unit. During the observation licensed practical nurse (LPN)-A was observed walking away from the medication cart and unit towards the nursing station. -At 7:55 a.m. LPN-A returned to the medication cart and locked the cart as surveyor stood there. On 11/15/18, at 11:32 a.m. the director of nursing (DON) stated medications and treatment carts were to be locked at all times when not in use. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to staff keeping medication carts secure and who may have access to medication carts. The DON or designee, could provide training for all nursing staff related to staff about the importance of securing the medication carts. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21610		