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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: LKWB
Facility ID: 00497

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245105**

2.STATE VENDOR OR MEDICAID NO.
(L2) **264638200**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE ESTATES AT ROSEVILLE LLC**
(L4) **2727 NORTH VICTORIA**
(L5) **ROSEVILLE, MN** (L6) **55113**

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) **03/01/2017**

6. DATE OF SURVEY **01/11/2019** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **175** (L18)

13.Total Certified Beds **175** (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
	175			
(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 01/15/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/15/2019 (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
08/01/1969
(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.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 15, 2019

Administrator
The Estates At Roseville LLC
2727 North Victoria
Roseville, MN 55113

RE: Project Number S5105031

Dear Administrator:

On December 11, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for, a standard survey, completed on November 29, 2018. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On January 11, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard standard survey, completed on November 29, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 4, 2019. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 29, 2018, effective January 4, 2019 and therefore remedies outlined in our letter to you dated December 11, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245105

January 15, 2019

Administrator
The Estates At Roseville LLC
2727 North Victoria
Roseville, MN 55113

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 January 4, 2019 the above facility is certified for:

175 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 175 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,

Kamala Fiske-Downing

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

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Facility ID: 00497

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(L3) **THE ESTATES AT ROSEVILLE LLC**
(L4) **2727 NORTH VICTORIA**
(L5) **ROSEVILLE, MN** (L6) **55113**

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) **03/01/2017**

6. DATE OF SURVEY **11/29/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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From (a) :
To (b) :

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13. Total Certified Beds **175** (L17)

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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
	175			
(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: Barbara White, HFE NE II — Date: 12/31/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL: Douglas Larson, Enforcement Specialist — Date: 01/14/2019 (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 **08/01/1969** (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. **01111** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 11, 2018

Administrator
The Estates At Roseville Llc
2727 North Victoria
Roseville, MN 55113

RE: Project Numbers S510503, H5105142

Dear Administrator:

On November 29, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required. In addition, at the time of the November 29, 2018 standard survey, the Minnesota Department of Health completed an investigation of complaint number H5105142 that was found to be unsubstantiated.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is January 8, 2019.

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:

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

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 March 1, 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 29, 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
	245105	A. BUILDING ______ B. WING ______	C 11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT ROSEVILLE LLC	2727 NORTH VICTORIA ROSEVILLE, MN 55113

(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 11/26/18 through 11/29/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted November 26 through 29, 2018 and a complaint investigation was also completed at the time of the standard survey. The complaint #H5105142 was completed and was found to be unsubstantiated. 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		1/4/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed | TITLE | (X6) DATE 12/20/2018

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 observation, interview and document review, the facility failed to provide choices related to morning rising routines for 3 of 3 residents (R42, R124, R64) reviewed for choices. Findings include: R42's quarterly Minimum Data Set (MDS) dated 9/25/18, indicated she was severely cognitively impaired, required extensive assist of one staff for bed mobility and transfers and was rarely or never understood. R15's care plan printed on 11/29/18, identified alteration in mobility and directed staff to assist with transfers using a mechanical stand.	F 561	• R42, R124 morning rising routines have been updated to reflect their preferences via the care plans and NAR care sheet. R64 was on hospice and has since passed away. • All residents have the potential to be affected if they are not provided with choices related to morning rising routines. • All residents rising preferences will be reviewed and care plans and NAR care sheets updated to reflect their choices. • A new preference form will be completed at the facility CMM meetings (which usually occur within 72 hours of admission). The preference form will	

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F 561	Continued From page 2 R124's quarterly MDS dated 11/6/18, indicated she was severely cognitively impaired and required extensive assist of one for bed mobility and transfers. R124's care plan printed on 11/29/18, identified alteration in mobility and directed staff to assist with transfers. R64's quarterly MDS dated 10/9/18, indicated she was severely cognitively impaired and required extensive assist of two for bed mobility and one for transfers. During an observation on 11/28/18, at 7:18 a.m. R64 was up in her wheelchair eyes closed and appeared to be asleep. At 8:14 a.m. R64, R124 and R42 were wheeled by staff to the dining room and seated in front of the table all three residents had their eyes closed and appeared to be asleep; At 9:06 a.m. R64, R124 and R42 were served their breakfast food and drink; staff tapped R124's shoulder and stated it was time to eat. R124 replied "I am so tired." The staff began to offer bites of food to R42 while her eye remained closed and needed verbal encouragement to open her mouth. R64 remained with her eyes closed and did not open her mouth despite staff attempts to tap her as they stated her name. At 9:33 a.m. R64 and R42 were in the dining room, both with eyes closed appearing to be asleep. During an observation on 11/29/18, at 7:17 a.m. R64 was laying dressed in her bed covered with a blanket. Nursing assistant (NA)-B stated she assisted R64 to get dressed around 6:30 a.m. then R64 told NA-B she was tired so NA-B assisted R64 back to bed. During an observation and interview on 11/29/18,	F 561	contain resident's rising preference. These preferences will then be reflected in the resident's care plan and on resident's assignment sheets. • The facility will provide education to all nursing staff, social services, and therapeutic recreation staff about resident self-determination and the new preference forms. • Director of Nursing/Designee will be responsible for conducting audits to ensure that resident's preferences are being collected and implemented. Audits will be conducted on all new admissions and 10 current residents per week x 3 weeks and reported to QAPI committee for further review and recommendations.	

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THE ESTATES AT ROSEVILLE LLC	**2727 NORTH VICTORIA ROSEVILLE, MN 55113**

(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 3 at 8:23 a.m. NA-B confirmed R42, R124 and R64 were seated in their wheelchairs with their eyes closed and asleep at the dining room table. NA-B stated R124 sometimes will inform staff she wanted to stay in bed and indicated they ask R124 if she was ready to wake up. NA-B stated R42 was at times already awake in the morning and if she was sleeping then they allow her a little extra time and then get her ready for breakfast. NA-B explained R64 at time is "so sleepy" during the morning they dress her and assist her back to bed to rest until breakfast. During an interview on 11/29/18, at 8:43 a.m. NA-A explained she started with the first resident room number listed on her care sheet when getting residents up and ready for the day. NA-A indicated she would wait until closer to breakfast to get a resident up if they were awake the night before. NA-A verified her care sheet did not indicate resident's preferred wake times. During an interview on 11/29/18, at 8:59 a.m. NA-C identified he went in the order of residents listed on his care sheet when waking residents up to get ready and stated "you need to get them to breakfast." NA-C explained residents who could talk could say no to waking up and some would scream so then you don't force them to wake up and those who don't refuse you wake them up and get them ready for the day. During an interview on 11/29/18, at 1:34 p.m. with registered nurse (RN)-B and social service (SS)-A; RN-B stated R64 would say "leave me alone" if she did not want to wake up, SS-A stated R124 would also say she was not ready to wake up and further stated R42's spouse wanted her up for every meal. RN-B identified the therapeutic	F 561		

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F 561	Continued From page 4 recreation department completed an interview on personal preferences upon admission. During an interview on 11/29/18, at 2:12 p.m. therapeutic recreation assistant (TR)-A indicated they do ask about resident preferences, however they do not ask about preferred wake times. A facility policy related to resident choices was requested but not received.	F 561		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the	F 578		1/4/19

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F 578	Continued From page 5 requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident's resuscitation status order matched the resident's stated request of Cardiopulmonary Resuscitation (CPR) for 1 of 1 residents (R27) reviewed for advance directives. Findings include: R27's diagnoses included atrial fibrillation, chronic obstructive pulmonary disease, angina pectoris, malignant neoplasm of tongue, tracheostomy and acute respiratory failure with hypoxia obtained from the admission record dated 11/28/18. R27's admission Minimum Data Set (MDS) dated 9/18/18, indicated R27 was cognitively intact, was able to make himself understood, and usually understood others. The MDS also indicated it was very important to R27 to have family or a close friend involved in discussions about his care. R27's Physician's Orders for Life Sustaining	F 578	• R27's resuscitation order was reviewed and updated to match the resident's request for CPR via the POLST form once it was found not to match on 11/28/2018. • All residents have the potential to be affected if their resuscitation status orders do not match their stated preference for advanced directives. • All resident's resuscitation orders and stated preferences were audited to ensure residents preferences were reflected accurately. This was done immediately during the survey process on 11/28/2018. • The facility has since reviewed the process of documenting code status and POLST documentation and put in to place re-education with nursing personnel. • Director of Nursing/Designee will continue to review POLST orders and match them to resident's preferences upon admission, with scheduled MDS reviews, significant changes, and as	

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F 578	Continued From page 6 Treatment (POLST) were reviewed and indicated "Cardiopulmonary Resuscitation" (CPR). R27 signed and dated the POLST on 10/11/18. The POLST was signed and dated by a nurse practitioner on 10/11/18. R27's Initial/Comprehensive care plan dated 8/16/18, indicated R27's current code status was Cardiopulmonary Resuscitation (CPR). R27's Order Summary Report dated 11/28/18, identified and order for DNI/DNR dated 11/21/18, however, the medical record lacked documentation whether a clarification had been obtained to change R27 from a Full code prior to hospitalization. On 11/28/18, at 8:16 a.m. licensed practical nurse (LPN)-A assigned to R27 stated if she needed to know any resident code status she would look at the orders tab in Point Click Care (PCC) which usually listed the code status on the top. LPN-A verified R27 current listed code status was DNI/DNR. On 11/28/18, at 9:06 a.m. when asked what his wishes were R27 stated he wanted staff to do CPR if they found him unresponsive. On 11/28/18, at 9:10 a.m. registered nurse (RN)-A verified the medical records did not matching pertaining to the resident advanced directive. RN-A stated the nurses were supposed to make sure it was addressed. RN-A stated R27 had recently been at the hospital and was re-admitted to the facility on 11/21/18, and at that time staff reviewed and verified the orders. She stated she would have expected them to verify the POLST and orders matched and if not, they	F 578	needed. • The QAPI committee will examine the results of these reviews and will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process	

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F 578	Continued From page 7 were supposed to get a clarification. RN-A reviewed the hospital discharge orders and verified R27's code status was DNI/DNR. On 11/28/18, at 2:13 p.m. the interim director of nursing stated staff were to follow the policy regarding assessing the code status and stated "when residents come to the facility we ask the nurses to ask the resident their POLST wishes and we go by what the resident wants. When he was re-admitted from the hospital with the DNI/DNR order I would have expected the nurse to have clarified with the resident and in this situation the ball was dropped when he came back. We will start right away to audit."	F 578		
F 603 SS=D	Free from Involuntary Seclusion CFR(s): 483.12(a)(1) §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 residents (R490) were free from involuntary seclusion.	F 603	• R490 voluntarily moved to the Victoria secured unit on 11/5/2018. After review, R490 was relocated off the secured unit to the TCU on 12/3/18. R490 was	1/4/19

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Continued From page 8

Findings include:

R490 was admitted to the nursing home on 11/2/18, to the transitional care unit (TCU), with diagnoses that included unspecified dementia without behavioral disturbances. The admission Minimum Data Set dated 11/22/18, identified R490 had a score of 14 on the brief interview for mental status (BIMS), a score of 13-15 indicated a resident was cognitively intact. Review of the medical record indicated R490 was transferred to the Victoria secured unit on 11/5/18.

On 11/28/18, at 8:34 a.m. R490 approached the surveyor on the Victoria secured unit and asked for coffee. Staff attempted to re-direct R490 to the dining room and R490 said that he didn't want to sit down and "stare at the wall". At 8:53 a.m. R490 was observed in the dining room at his table with his back to the door and facing a book case that was up against the wall.

On 11/29/18, at 9:00 a.m. R490 approached the surveyor on the Victoria secured unit. R490 said that he felt like he was in prison and that he can't get past the doors. R490 said that he had not tried to leave, he knew that he could not go back to his home but "getting off the memory care unit" would help. R490 expressed frustration because there was no one to talk to because most of the residents on the unit don't talk. R490 indicated the social worker was assisting him to go to an assisted living facility. R490 said the staff thought he was crazy and they didn't want him to call the unit a prison. R490 asked what would you call it if you can't leave? He told the surveyor that he walked around the Victoria secured unit because if he sat in his room the "walls would close in on me".

F 603

discharged from the facility to an ALF on 12/17/18.

- All residents residing on the secured memory care units have the potential to be affected if a resident is placed on a unit without proper assessment and qualifications.
- All the residents that reside on the secured units will be reviewed to ensure each resident is free from involuntary seclusion.
- The facility will review each resident residing on a secure unit upon transfer, admission or at least quarterly or during significant changes to ensure each resident is free from involuntary seclusion. This review will be documented in a progress note or on the care conference form.
- The facility will provide re-education to nursing and social services staff on the criteria for the secure units at the facility as well as involuntary seclusion and the process for reviewing each resident for appropriate placement on the secured units.
- Social Service Director/Designee will continue to review placement of residents demonstrating behavioral activities upon admission, with scheduled MDS reviews, significant changes, as needed and reported to QAPI committee for further review and recommendations.

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F 603	Continued From page 9 Licensed practical nurse (LPN)-C was interviewed on 11/29/18, at 12:55 p.m. LPN-C said R490's significant other came in daily to visit. LPN-C felt that R490 would do better on the Woodhill secured dementia unit because there would be more residents to talk with on that unit. LPN-C said R490 liked to be in his room, he had never made any attempts to leave and did not require any redirection. LPN-C was not sure why R490 was even on the Victoria secured unit. Registered nurse (RN)-B and licensed social worker (SS)-A were interviewed on 11/29/18, at 1:15 p.m. and identified that R490 was admitted on to the transitional care unit (TCU) and was up at night and went into other resident's rooms and rummaged through other resident's things and the residents on the TCU unit were frustrated with R490. SS-A said it was brought up at the interdisciplinary team (IDT) meeting that it was not appropriate for R490 to be on the TCU. SS-A said she and RN-B went to TCU to review R490 and said he could come with them to the secured Victoria unit. SS-A said since R490 has been on the secured Victoria unit, R490 had not gone into other resident's rooms or rummaged through other resident's things. RN-B said there was a conversation at the IDT meeting and it was presented to RN-B and SS-A by the nurse manager from TCU that R490 was not appropriate for the TCU. RN-B and SS-A indicated that R490 was fairly independent and that SS-A was working on finding him an assisted living facility to transfer to.	F 603		

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F 603	Continued From page 10	F 603		

Continued From page 10

Most of R490's days were spent with his significant other and they watched television and walk to the TCU unit and sat in the front lobby. Both RN-B and SS-A said R490 had not tried to leave the secured Victoria unit and neither RN-B and SS-A had any concerns about R490 exit seeking or leaving the facility.

SS-A said that a long term care unit bed (not in the secured unit) would be a better fit for R490 however he currently has a single room on the secure Victoria unit and SS-A felt that R490 would do better in a single room and currently there were no single rooms available on the long term care unit.

SS-A identified that R490 would be better on the other secure dementia unit (Woodhill) because there were more alert and oriented residents there that R490 could converse with. SS-A said there were only double rooms available on that unit and R490 was not offered to tour that unit or see the room that was available when he was transferred to the Victoria secured unit.

RN-B identified that R490 was definitely at a different level of socialization compared to other residents on the Victoria secured unit and that R490 was not offered any other room options within the facility. Both RN-B and SS-A were not aware that R490 did not want to be on the secured Victoria unit.

RN-B and SS-A identified the criteria for a secured unit included; a resident exhibiting exit seeking behaviors, had a cognitive impairment and/or would benefit from activity programs.

Director of nursing (DON) was interviewed on

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F 603	Continued From page 11 11/29/18, at 1:57 p.m. The DON indicated the criteria for placement on a secure dementia unit included a diagnosis of dementia or Alzheimer's and if a resident was at risk for wandering, and if they were at risk to themselves or others. When placing someone on a secured dementia unit there should be a conversation with the family and the resident, the family and resident should tour the area and be involved with the decision to move. The DON identified there would be an elopement risk assessment done for all residents prior to placement on the secured units. The DON said R490 was not an elopement risk and didn't feel that R490 was advanced enough in his dementia to be on the Victoria secure unit and was unsure how R490 ended up on the unit. RN-C was interviewed on 11/29/18, at 2:17 p.m. RN-C (who worked as an RN on the TCU) indicated that if a resident was rummaging, in other resident's rooms and depending on their level of dementia, they may be safer on a dementia unit. RN-C said R490 was rummaging and wandering into other resident's rooms while he was on the TCU. RN-C said this information was brought to and IDT meeting and a decision was made from there to move R490 to the Victoria secured unit. RN-C said the TCU had higher functioning residents and the memory unit would be better suited for R490's needs due the wandering and rummaging. Administrator was interviewed on 11/29/18, on 2:37 p.m. When asked for the criteria for a secured memory care unit the administrator indicated a resident would have a neurocognitive disorder, exhibit signs of exit seeking and benefit from additional programming. The administrator indicated the family would be involved in the	F 603		

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F 603	Continued From page 12 decision process. Review of progress notes identified that R490 was noted to rummage in his own drawers and closet in his room on the TCU, wandered on the TCU but made no attempts to leave and mistakenly went into another TCU resident's room and was easily re-directed. There were no nursing notes to identify a discussion was held in regards to R490 being moved to the Victoria secured unit. R490 was provided a room change form and he signed it himself to change rooms from the TCU to the Victoria secured unit. Progress note on 11/4/18, at 1:35 a.m. identified R490 was noted to rummage through his drawers and his closet. Denied any pain when asked, no behavioral issues, pleasant with staff, sitting in the lobby having a snack, no exit seeking behaviors, easily re-directed, frequent safety monitoring continues thru (sic) out the shift. Progress note on 11/4/18, at 9:43 a.m. identified R490 exhibited wandering behaviors on unit, no attempts of exit seeking or leaving unit. Client did enter another client room mistakenly while looking for his own room; easily redirected. Progress note on 11/5/18, at 1:58 a.m. identified R490 was rummaging around his room, going from one bed to another in his room...no exit seeking, pleasant with staff, no negative behaviors, frequent safety monitoring continues thru out shift. Progress note on 11/6/18, at 3:34 p.m. identified R490 was adjusting to his new environment well. No wandering/exit seeing observed. There is no nursing note to identify that R490 was transferred	F 603		

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F 603	Continued From page 13 to a different unit or why he was transferred. Progress note on 11/10/18, at 9:23 p.m. during rounds R490 asked staff why he was on this unit as other residents have wandered in the room and does not like it. He further stated that he wanted to go home. Progress note on 11/18/18, at 9:44 p.m. R490 stated to staff that he felt like a caged animal and that he wished that he could go home. An Elopement Risk Evaluation assessment dated 11/13/18, was reviewed for R490. The score was 7 (0-14 was no risk). The assessment identified R490 had not history of elopement attempts, was fully ambulatory, accepting of the placement, had disorientation but no wandering, no behaviors noted, was on one antipsychotic medication, and had a diagnosis of dementia. The last question on the assessment read: If at risk for elopement, what prevention measures are being implemented and the response was Special Care Unit. The summary and interventions indicated: Resident is not a risk for elopement, placed on secure unit related to dementia. A policy was requested for the criteria for admission to a secured unit. The untitled and undated policy listed memory care criteria: 1. Have a major neurocognitive disorders or show sign and symptoms of major neurocognitive disorders. 2. Patients would typically benefit from increased, specialized programming and/or a controlled access living environment. 3. Qualify for skilled nursing level of care or custodial care where all needs can be met.	F 603		
F 604	Right to be Free from Physical Restraints	F 604		1/4/19

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F 604 SS=D	Continued From page 14 CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 residents (R43) were free from the use of physical restraints.	F 604	• The pillows and cushion were removed from under R43's bed immediately on 11/29/2018. • R43's care plan was reviewed and revised to ensure proper interventions for	

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F 604 Continued From page 15
Findings include:

R43's admission Minimum Data Set (MDS) dated 9/25/18, indicated R43 was severely cognitively impaired and required extensive assist with bed mobility and transfers. R43's initial care plan dated 9/25/18, identified R43 was at risk for falls related to dementia with behavioral disturbances, required the use of a wheelchair and had impulsive behaviors. Interventions included: bed in lowest position, mattress on floor next to bed as resident was known to crawl out of bed around on the floor while refusing to allow staff to assist to chair. The nursing assistant care guide, identified R43 was a high fall risk and mattress on the floor when in bed related to resident crawling out.

During an observation on 11/29/18, at 7:11 a.m. R43 was lying in bed. The bed was positioned with one side against the wall. R43's wheelchair was at the other side of R43's bed, there was no floor mat noted on the floor beside R43's bed. Bed was noted to be in the lowest position. Nursing assistant (NA)-A assisted R43 with morning cares. R43 was observed to have two pillows on R43's left side. The pillows were tucked under the fitted sheet of the bed. Prior to getting R43 out of bed NA-A took a cushion out from under the mattress. The cushion was approximately two feet long and one foot wide and 6 inches in height. The cushion was labeled "heel management".

While NA-A was assisting R43 to the bathroom for morning cares, licensed practical nurse (LPN)-B was in the room. LPN-B indicated R43 had been seen crawling out of bed and scooting on her behind on the floor in her room.

F 604

falls and heel protection.

- All residents have the potential to be affected if physical or chemical restraints are used that do not treat the resident's medical symptoms.
- An audit of every resident will be completed to ensure no other residents were being restrained in a similar manner. This incident did appear to be an isolated incident.
- Education on restraints will be provided to nursing staff to ensure there is clear understanding on definition of restraints.
- Director of Nursing/Designee will be responsible for conducting audits. Audits will be conducted at 20 residents per week x 3 weeks and reported to QAPI committee for further review and recommendations.

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THE ESTATES AT ROSEVILLE LLC	**2727 NORTH VICTORIA ROSEVILLE, MN 55113**

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F 604	Continued From page 16	F 604		

Continued From page 16

During an interview on 11/29/18, at 7:45 a.m. NA-A indicated that she didn't normally work on this unit and when she did work on the unit, she worked the p.m. shift as a trained medication assistance (TMA). NA-A was not sure if the pillows under the fitted sheet and heel cushion under the mattress were normally there however when she had worked on the p.m. shift in the past she had observed them.

LPN-C was interviewed on 11/29/18, at 7:51 a.m. LPN-C said that R43 used to have a personal alarm on her bed and that was removed. When asked about the heel management cushion, LPN-C said that it was used to off load R43's heels. LPN-C said the floor mat was removed and now the heel cushion was put on the floor so if R43 crawled out of bed she wouldn't land hard on the floor. LPN-C stated that the heel cushion should not be put under the mattress or the pillows put under the fitted sheet if it would prevent R43 from getting out of bed on her own.

Registered nurse (RN)-B was interviewed on 11/29/18, at 7:59 a.m. RN-B said when R43 was first admitted, the facility was using a fall mat and now were conducting a trial without the fall mat. The heel management cushion was used to float R43's heels as a preventative measure. RN-B said it was not typical to tuck the heel cushion under the mattress or the pillows under the fitted sheet. RN-B was not aware how staff were using the cushion or the pillows.

The director of nursing (DON) was interviewed on 11/29/18, at 1:37 p.m. The DON indicated that if a resident was able to get out of bed on their own and had pillows underneath the fitted mattress

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F 604	Continued From page 17 sheet and a heel management cushion under the mattress it would be considered a restraint. A facility policy titled Restraints dated (undated) was reviewed. The policy indicated there would be documentation of consent for the use of a restraint in the resident's medical record with the discussion of risks and benefits along with a physician's order and a "Restraint Assessment" form. R43's record was reviewed, there was no discussion of risks and benefits of the pillows or heel management cushion that were used, no physician's order and no restraint assessment found.	F 604		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide meaningful and individualized activity programs for 1 of 1 residents (R73) reviewed for activities. Findings include: R73 face sheet dated 11/29/18 indicated diagnoses including pain, depression, and	F 679	• An activity assessment was completed with R73 during the survey process and resident's activity care plan updated to reflect preferences, recommendations, and functioning of equipment used for communication. • R73 was given a functional pocket talker and will be asked if he wants to see an audiologist for additional hearing	1/4/19

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F 679	Continued From page 18 insomnia. R73's significant change minimum data set (MDS) dated 10/11/18 indicated R73 had moderate cognitive impairment, and it was very important to him to have books, know the news, get outside, and do his favorite activities. There was no staff data entered for activities. There was no activity assessment in the medical record. There was no care area assessment completed for activities. The care plan dated 11/7/18 indicated that R73 only wanted to be in bed and that a pocket talker and independent leisure supplies should be provided. 1:1 visits to be provided by activities. An assessment dated 10/3/18 by a psychologist indicated that the consultation was to improve the quality of life and level of functioning for R73. The consultation recommended "distraction suggested as primary deterrent from anger and rumination on circumstance. He'll need prompting to engage in activities and perhaps a start with bringing activities to him in bed." Review of the documentation of activities for R73 indicated 2 visits in September 2018, 3 visits in October 2018, and 2 visits in November 2018. During an interview with R73 on 11/27/18 at 8:55 a.m. he stated he chose not to go groups or activities because he couldn't hear. He stated he had been given a pocket talker (an amplification device) a couple of weeks ago but the headphones didn't work when he tried it. He said he wished he could be in a room with a better view since he stayed in bed. He was observed to	F 679	support. • All residents have the potential to be affected if meaningful and individualized activity programs are not provided based on resident's preferences. • All resident's activity assessments will be reviewed, and care plans updated based on resident's preferences and recommendations. • The therapeutic Recreation Department will receive education regarding the requirement to provide each resident with an ongoing program to support them in their choice of activities based on their interested. • Social Services Director/Designee will conduct audits on all new admissions and 10 residents per week x 3 weeks and reported to QAPI committee for further review and recommendations.	

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F 679	Continued From page 19 be in his bed, lying on his back with no TV or radio. There were no activity materials in the room. R73 was not observed to be out of his room on any of the days of the survey, or engaged in activities. On 11/29/18 at 10:00 a.m. the director of social services was interviewed and stated that all the recommendations from the psychology consults would be communicated to the treatment team. She stated that all the recommendations should be considered and included in the care plan when possible. The activity director was interviewed on 11/29/18 at 8:30 a.m. and stated she was assigned to R73. She stated R73 did not attend groups and had only 1:1 visits from her staff. 1-3 times a week She verified that there was no activity assessment in the record, and she didn't know why R73 stayed in bed. She verified that an activity assessment should be completed with each full MDS. She stated she had not been aware of the recommendations from the psychologist. She also verified that R73 should have a pocket talker to use when visiting. At 10:20 a.m. the activity director met with R73 and checked the pocket talker and stated it did not work. R73 told her he would like to have a headset that worked, and a TV or radio in his room.	F 679		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		1/4/19

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F 689	Continued From page 20 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to reduce the risk for fall for 1 of 5 residents (R78) reviewed for falls. Findings include: R78 quarterly Minimum Data Set (MDS) dated 10/16/18, indicated she was severely cognitively impaired and required extensive assistance with all activities of daily living. The MDS included R78 required limited assistance for walking and balance was only able to stabilize with human assist. R78's care plan dated 10/26/18, identified R78 was at risk for falls and directed staff to keep extra chair out of residents room to maintain a clutter free environment, observe for unsafe movements, encourage use of walker, low bed, and to wear gripper socks at night. A review of R78's Fall Review Evaluation dated 10/15/18, indicated she had two falls during past six months and to monitor for increased knee pain and decreased mobility. A review of facility incident reports indicated R78 had a history of falls on 10/2/18, 10/5/18, 10/21/18, 11/6/18, 11/11/18 and 11/21/18. During an observation on 11/28/18, at 9:45 a.m. R78 was walking in common area without assistance or walker; nursing assistant (NA)-D approached R78 and stated let's go back to your	F 689	• R78's care plan was reviewed for fall interventions and R78's care sheet was updated to reflect those interventions. • All residents have the potential to be affected if the facility fails to implement interventions to reduce the risk of falls. • All resident's care sheets will be reviewed and updated to reflect current fall interventions. • The NAR care sheets will be adjusted to include fall interventions for each resident, as applicable. • Director of Nursing/Designee will be responsible for conducting audits. Audits will be conducted at 20 residents per week x 3 weeks and reported to QAPI committee for further review and recommendations.	

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F 689	Continued From page 21 room held R78's left hand and guided R78 back to her room. At 10:10 a.m. R78 was observed walking around her room without walker; NA-D guided R78 to her bed and verified R78's bed was able to go low to the floor, however it was supposed to be approximately two to three feet higher than the lowest position when occupied for ease of transfers. At 10:30 a.m. NA-D confirmed R78 did not have her walker within reach and it had been left in the dining room out of R78's reach since breakfast. During an observation and interview on 11/29/18, at 10:46 a.m. NA-C confirmed R78 was lying in bed and her bed was approximately 3 feet higher than the lowest position, her walker was out of reach near the bathroom door and explained the extra chair in her room was for visitors and was supposed to be there. During an interview on 11/29/18, at 1:45 p.m. registered nurse (RN)-B stated R78's fall interventions included bed to be in lowest height position, encourage use of walker when walking and no chairs should be left in R78's room. RN-B confirmed R78's fall interventions were not listed on the NA care sheet. During an interview on 11/29/18, at 2:43 p.m. the interim director of nursing (DON) stated it was her expectation the NA care sheet was updated with current fall interventions to match the care plan. The facility protocol Falls Prevention and Management Protocol revised date 7/2018, indicated "The purpose of this protocol is to identify resident at risk for falls, implement fall prevention interventions..."	F 689		

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F 697	Continued From page 22	F 697		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess and implement interventions to reduce pain for 1 of 5 residents (R73) reviewed for pain. Findings include: R73 face sheet dated 11/29/18 indicated diagnoses including unspecified pain, low back pain, and joint pain. A nurse practitioner note dated 8/6/18 indicated R73 had a left hip fracture from a recent fall. R73's significant change minimum data set (MDS) dated 10/11/18 indicated R73 had moderate cognitive impairment, and had pain frequently, sometimes severe, and had no non-pharmalogical interventions identified for pain. R73's care area assessment dated 10/18/18 indicated R73 reported frequent, severe pain, consideration of recent fracture of the hip. The Pain Evaluation dated 10/11/18 also indicated frequent severe pain and noted no schedule pain medication or non- pharmalogical interventions for comfort. The assessment noted R73 had 1 as needed dose of Tylenol.	F 697	• R73's pain assessment 10/11/18 was reviewed and MD notified of resident's concerns regarding pain management immediately during the survey process. Another pain assessment was completed for R73 on 12/19/2018. • R73's Pain medication has been adjusted by the MD/NP and R73's care plan was revised to reflect pharmacological and non-pharmacological interventions. • All residents have the potential to be affected if the facility fails to comprehensively assess and implement interventions to reduce pain. • The MDS nurses or designees will report completed pain assessments to the clinical IDT meetings to ensure effective pain management plans are implemented for each resident. • The facility policy for Pain Management was reviewed and remains applicable. • Education will be completed with nursing staff regarding F697 and the facility Pain Management policy and the process for developing effective pain management plans and implementing	1/4/19

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F 697	Continued From page 23	F 697		

F 697

The current care plan dated 10/26/18 indicated R73 had an alteration in comfort related to a fractured hip and gastrointestinal reflux. The care plan directed staff to assess pain and provide medication, rest, repositioning, or massage if indicated.

A hospital discharge summary dated 8/29/18 indicated that R73 had been hospitalized from 8/25/18 to 8/29/18 for an altered mental status caused by an overdose of Methadone. Methadone is a narcotic pain medication used to treat severe pain. The discharge summary indicated an interaction with Methadone and a new seizure medication, and included a recommendation to consider a retrial of a non narcotic medication, or a lower dose of Methadone.

The note from the nurse practitioner dated 9/25/18 did not address the recent hospitalization and change in pain medications.

R73 was interviewed on 11/27/18 at 09:20 a.m., and stated he does not get up due to pain, he said that since he came back from the hospital he only takes as needed (prn) over the counter medications. He said he doesn't bother taking them because they do nothing. R73 stated he can't take narcotics. He was observed to be lying in bed on his back, and moved legs and arms freely.

R73 was interviewed on 11/29/18 at 9:30 a.m., and stated his pain is bad today, but didn't tell the nurse because all they do is offer aspirin, and that doesn't help. He stated getting up hurts so he stays in bed, he stated he sometimes had

F 697 (Plan of correction)

non-pharmacological interventions for pain.

- Director of Nursing/Designee will be responsible for conducting audits for pain assessments and non-pharmacological intervention use. Audits will be conducted at 20 residents per week x 3 weeks and reported to QAPI committee for further review and recommendations.

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F 697	Continued From page 24 problems sleeping, and sometimes the pain would be gone for several days. He was observed to be lying in bed on his back, and able to independently roll to each side. RN-A came into the room and assessed R73 and agreed she would call the doctor for orders. During an interview with RN-D on 11/29/18 at 07:30 a.m. regarding the MDS pain assessment. She stated a significant change MDS was done due to decline and weight loss. She stated the assessment was difficult to complete because of inconsistent reports from R73. She verified that non pharmalogical interventions were not assessed at this time. She stated she was aware of the change in medications for pain since the hospitalization and that R73 does not ask for the prn medication for pain She verified the assessment did not address where the pain occurred, she stated the assessment doesn't balance out the recent change in treatment for pain. Nursing assistant-D was interviewed on 11/29/18 at 9:22 a.m., and stated that R73 sometimes complained of pain in his legs, and will get out of bed with encouragement. She stated she would tell the nurse if he had pain but R73 would refuse to take medication offered. she stated R73 would direct his care and it was important to offer him choices. LPN- D was interviewed on 11/29/18 at 10:00 a.m. and stated R73 sometimes will refuse mediations, and his ain control is pretty good. She stated she asked daily if he had pain and he will tell her. She stated he got up only a couple of times in the past month, and had no complaints	F 697		

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F 697	Continued From page 25 of pain when up. RN-A stated in an interview on 11/29/18 at 9:30 a.m., that ongoing pain assessment is done with R73 and the pain level varies, he often refuses medication. The facility policy for pain management (undated) indicated that the interdisciplinary team should identify causes of pain, and evaluate for non pharmalogical interventions to address pain.	F 697		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dementia services were provided for 1 of 5 (R12) residents, and adjustment needs were identified and behavioral interventions shared with staff for a new resident that exhibited signs and symptoms of restlessness and agitation for 1 of 5 (R487) residents. Findings include: R487's Admission Record identified an admission date of 11/21/18, with diagnoses that included: Dementia with behavioral disturbances, restlessness and agitation. An initial care plan was requested however was not provided. The nursing assistant care resident information sheet	F 744	• R487 transferred to the hospital on 11/27/18 and family chose not to hold the bed, so the resident was ultimately discharged. • R12 care plan was updated with resident's preferences and appropriate behavioral interventions. • All residents with a diagnosis of dementia have the potential to be affected. • All residents with a diagnosis of dementia will have their care plans reviewed to ensure behavioral interventions and preferences are up to date. NAR sheets will be reviewed to reflect appropriate behavioral interventions.	1/4/19

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F 744	Continued From page 26 identified R487 had multiple hallucinations and behaviors and directed staff to re-approach R487 if refusing cares. The care guide further indicated R487 would sit or lay on the floor, and take objects apart and carry them around. R487 was observed on 11/26/18, at 12:21 p.m. in the dining room. R487 came up to the surveyor and asked when he could go home. R487 said he ate three times already that day and he was upset because he needed his insulin. R487 was independent and walked through out the secured Victoria unit without the use of any assistive device. R487 was observed on 11/26/18, throughout the afternoon and early evening walking around the Victoria unit and exit seek. R487 would sit down on chairs by the nursing station for a few minutes then would get back up again. He asked staff and visitors when he could go home and how he could leave the unit. He appeared upset when staff attempted to re-direct him. R487 was observed on 11/27/18, after breakfast pacing throughout the unit. He looked for his camera and asked staff if they knew where it was. R487 was observed at the exit doors and attempted to leave. Review of facility Progress Notes identified the following: On 11/23/18, at 4:59 a.m. indicated R487 was up all shift with agitation, pacing up and down the halls, in and out of other resident's rooms, unable to redirect. The note indicated R487 denied any pain when asked and accepted food and fluids. R487 refused PRN (as needed) medications.	F 744	• Education about F744 and Dementia Care will be provided to nursing and social service staff. • Monthly dementia huddles will be conducted on the dementia care units to provide dementia-related training to staff as well as solicit feedback from staff about effective behavioral interventions for each resident. • Social Services Director/Designee will be responsible for conducting audits of care plans for appropriate behavioral interventions. Audits will be conducted at 10 residents per week x 3 weeks and reported to QAPI committee for further review and recommendations.	

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Agitation escalated with exit seeking and swinging at staff. R487 was in the dining room when writer heard screaming with loud banging, writer observed resident fighting and swinging with no one else present, it almost appeared that he was being punched in the face, his head would jerk and he would throw himself against the wall, R487 then sat on the floor, looked up and said, "leave me alone"....a few minutes later he attempted to leave unit going door to door. R487 managed to open the doors and run down the 400 hallway. He was extremely agitated and was becoming abusive to staff. R487 then proceed to climb up onto the nursing desk on the long term care unit, his gait was unsteady and he almost fell numerous times. He was stating his blood sugar was low but refused a blood sugar check. Due to the potential for harming himself or staff, 911 was called for assistance. When police arrived R487 de-escalated some and did allow a blood sugar and was compliant with taking Olanzapine (antipsychotic medication) PRN, the police escorted R487 back to the Victoria unit where once again he became agitated and was arguing with the police. R487 wanted to go to the hospital but the police were reluctant to send him. Around 4:30 a.m. the Olanzapine had been ineffective. The on call physician was notified of the situation and gave an order for Seroquel (antipsychotic medication) 25 mg. The police spend an hour with R487 until he went to sleep.

On 11/23/18, at 10:16 a.m. indicated R487 had behaviors of pacing in the hallway, anxiety, displayed delusional thoughts, hallucinations displayed by picking up things that were not there.

On 11/23/18, at 11:11 a.m. indicated R487 flipped

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a dining room table over in the doorway of the dining room, barricading himself in the dining area. Staff were able to flip the table back up but R487 tried to push it back down again. Staff were able to get R487 out of the dining area to the hallway. After review of all reported incidents staff called for recommendation from the primary physician. R487 was sent to the hospital on 11/23/18, related to danger to self and others, hallucinations, exit seeking, crying and yelling and aggressive behaviors toward staff.

On 11/23/18, at 8:00 p.m. R487 returned to the facility.

On 11/24/18, at 11:22 a.m. R487 was restless at 7:00 a.m., pacing in the hallway and wandering into other resident's rooms. R487 attempted to sit on other residents and stated "why are you so stupid? Get my bags, I'm getting out of here." R487 was redirected back to his room where environment was quiet but came straight out of his room and continued to pace the unit....Resident is difficult to redirect at times.

On 11/24/18, at 9:20 p.m. R487 was restless and pacing the unit all afternoon and into the evening. Redirection given multiple times

On 11/25/18, at 9:10 p.m. R487 continued to be restless and agitated especially after family left in the afternoon.

On 11/27/18, at 12:50 p.m. note indicated R487 had been agitated and pacing the unit all morning and afternoon, pounding on the exit doors, rummaging in and out of other resident's rooms, removing their belongings and unable to re-direct. R487 was digging through the garbage cans and

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throwing everything out of them onto the floor, crawling under the dining room tables and trying to flip the tables over as well as hitting and kicking at the windows trying to get out. When asked what he was looking for R487 said his camera. He then began to feel the sleeve of SS (social services) shirt and stated, "My camera is here, your using the wrong lens give it to me so I can fix it." SS attempted to re-direct R487. Then he grabbed the program manager's hand and explained to her that her fingers were the different lens covers and she needed to sit still to get it covered up." R487 was distressed by his hallucinations and having delusional thoughts. He continued to enter rooms and crawl under the beds trying to lift them up with his back, stating he is going down stairs. Res. then proceeded to pull the call lights out of the wall and unplug the bed remotes. Res. was given a television remote which he believed was his camera and had been holding it up to his eye and trying to take pictures of people by hitting the buttons on the remote. Staff were providing a 1:1 due to impulsive behavior and a risk to himself and others.

A subsequent note dated 11/27/18, at 2:16 p.m. indicated social services contacted R487's daughter regarding a bed hold. There were no further progress notes in the record to identify R487 going to the hospital.

Interview on 11/28/18, at 2:25 p.m. registered nurse (RN)-B said that R487 was still at the hospital and the hospital was looking for a place for him. RN-B stated the hospital did want to keep him and because of his dementia was not appropriate for psychiatric services.

Licensed social worker (SS)-A was interviewed

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on 11/29/18, at 8:40 a.m. SS-A said prior to R487's admission on 11/21/18, R487 was on one to one monitoring at the hospital. SS-A said the facility was told the one to one monitoring was for wandering, not for aggression or hallucinations. SS-A was asked the status of R487 after he was re-admitted to the hospital on 11/27/18. SS-A said that R487 was at the hospital and the hospital was looking to possibly admit R487 to the geriatric psychiatric unit. SS-A thought that R487 was admitted to the hospital and indicated that R487 was on a bed hold.

Nursing assistant (NA)-E was interviewed on 11/29/18, at 10:00 a.m. NA-E was asked about R487 and what interventions were identified for him when he was agitated or upset. NA-E said that staff needed to leave him alone and re-approach later. NA-E said when R487 was upset and wanted to go home, she would tell him that he lived at the nursing home now and he needed to stay on the unit.

Licensed practical nurse (LPN)-C was interviewed on 11/29/18, at 10:14 a.m. LPN-C said the first time she worked with R487 was when he came back from the hospital on 11/23/18 and stated when she worked with R487 she noticed that he was irritated. LPN-C stated she would read his facial expression and would re-approach him if needed. LPN-C worked on the unit on 11/27/18, when R487 went to the hospital but stated she was unaware that R487 had pushed over tables in the dining area prior to staff sending him to the hospital.

Family member (FM)-A was interviewed on 11/29/18, at 12:21 p.m. FM-A indicated that she did not get a lot of information from the facility.

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FM-A stated she would call and ask how R487 slept and staff would tell her that they just started their shift and did not know. When the facility sent R487 to the hospital, FM-A said the facility called and said, "Your dad is misbehaving and we are sending him to the hospital". FM-A was asked if the facility asked her about interventions for R487 to help with his agitation or restlessness and said the facility had never asked her any ideas or suggestions to help R487 with agitation, restlessness or adjustment to the facility.

RN-B and SS-A were interviewed on 11/29/18, at 10:23 a.m. and stated R487 had been on a one to one most of the time that he had been at the nursing home. RN-B and SS-A were aware that R487 was on a one to one at the hospital but thought that was for wandering. The indicated at the facility, R487 was on one to one for wandering, agitation and exit seeking. RN-B said R487 was difficult to re-direct.
When R487 was sent to the hospital on 11/27/18, RN-B said that he was very agitated and looking for his camera. RN-B said activity staff was looking to find a camera. When asked if there were interventions that may work with R487, SS-A said they were aware that R487 like to read the newspaper and liked cameras and stated approaches were used with R487 to re-direct him to look at the newspaper but no attempts were made to find a camera for him to use nor had they asked family to bring one in. SS-A said her communication with the family was to call and ask the daughter if she would like the bed to be held when R487 went to the hospital. SS-A stated when R487 returned to the facility the evening of 11/23/18, SS-A was not in the building and then was gone for the weekend and had not had further conversations with the daughter as to

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F 744	Continued From page 32 what interventions or approaches might work well with R487. SS-A states she was not aware the wife's phone number was listed for R487. (Wife's name and phone number were listed on the admission record sheet as the second emergency contact). SS-A further indicated there had been no direction given to staff on interventions that may be helpful with R487 (newspaper and cameras). SS-A verified there was no direction on the nursing assistant resident information sheet for staff to be aware of or interventions to use with R487. Both RN-B and SS-A acknowledged they could have done a better job getting to know resident and to identify approaches and interventions and inform staff of those approaches and interventions. The director of nursing (DON) was interviewed on 11/29/18, at 1:37 p.m., and indicated that family was asked upon admission about likes and dislikes and what had worked in the past for residents, and if there were any triggers for behaviors the facility should be aware of. The DON stated typically a 72 hour care management meeting was set up but she was not sure if SS-A had the opportunity to set that up with R487's daughter. She stated if the meeting was not set up and a resident was exhibiting behaviors as R487 had been, the DON would expect staff to call and talk to family about inventions and to try to set up a meeting. R12's annual Minimum Data Set (MDS) dated 8/28/18, indicated R12 was severely cognitively impaired and required assistance with all activities of daily living. R12's care plan dated 1/12/18, identified R12 had a self-care performance deficit and directed staff to	F 744		

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anticipate needs and encourage him to participate to the fullest extent possible with each interaction. The care plan further identified behaviors regarding wandering, rummaging, exit seeking and pacing and directed staff to provide 1 to 1, redirect, reorient, speak in a calm voice, offer snack or television and take time to talk with him when he appeared not interested in things.

On 11/28/18, at 7:24 a.m. R12 was observed to enter room 926 someone in the room stated "do not come in here" R12 then attempted to enter the unit nurse office; licensed practical nurse (LPN)-C stated "this is my office I am begging you go that way." R12 attempted to exit the unit and sounded the door alarm registered nurse (RN)-B stated "hi buddy" and assisted R12 to turn the opposite direction. R12 entered room 934 and rearranged the dolls a nursing assistant (NA) stated " ...come let's go this way I have some juice for you, let's go this way;" R12 continued to follow NA down the hall and the NA entered the soiled utility room while R12 continued towards the dining room the NA went the opposite direction. At 7:41 a.m. R12 attempted to exit the unit then turned around and entered room 924; upon entrance the resident asked "what does he do if I knew what he did" NA tapped R12 on should and pointed with finger away from door R12 turned around and attempted to exit the unit NA yelled R12's name twice from approximately 10 feet away and R12 turned around.

During an interview on 11/28/18, at 1:26 p.m. NA-E stated R12 walked from room to room around the unit and identified telling R12 to come out or move worked to redirect R12.

On 11/28/18, at 1:45 p.m. R12 attempted to open

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door to the outside then paced in and out of dining room where activity was in progress. Activity assistant did not invite R12 to activity.

On 11/29/18, at 7:09 a.m. R12 attempted to exit unit; nurse walked by and did not intervene then attempted to enter room 924 nurse stated no, no go the other way. At 7:22 a.m. R12 entered room 931; resident in 931 stated "you don't belong here there's nothing here for you now let's go this way" and opened door as R12 exited room. The resident in 931 further stated R12 invaded his privacy and indicated when R12 entered his room he just tells him to leave.

During an interview on 11/29/18, at 8:52 a.m. LPN-C indicated it was normal for R12 to roam the unit and walk into others rooms all day and night. LPN-C stated they told R12 no or please get out of there. LPN-C explained she was unsure if R12 had any activities of interest and further stated R12's son had brought a couch and television for his room however, R12 did not ever watch it.

During an interview on 11/29/18, at 1:50 p.m. RN-B identified R12 liked television and would sit on the chair in his room and watched television for long periods of time and he especially enjoyed old movies. RN-B stated R12's television and movie preference was not written down however, was stated during verbal report. RN-B further indicated R12's preferences should have been added to his care sheet and confirmed it was not currently listed.

During an interview on 11/29/18, at 2:45 p.m. the interim director of nursing stated it was her expectation not to yell down the hallway to

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F 744	Continued From page 35 redirect a resident that she would expect the staff would have offered food, fluids and/ or television as a diversion and further identified these preferences should be listed on the care sheet. A facility policy related to dementia care was requested but not received.	F 744		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order	F 758		1/4/19

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F 758	Continued From page 36 unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to attempt non-pharmacological interventions prior to as needed (PRN) antipsychotic medication administration for 1 of 5 resident (R112) reviewed for unnecessary medications. Findings include: R112's admission Minimum Data Set (MDS) dated 11/6/18, indicated R112 had diagnoses which included dementia, depression and non-traumatic brain dysfunction. In addition, the MDS indicated R112 received antipsychotic and anti-depressant medication for seven days during the reference period. During an observation on 11/28/18, at 7:11 a.m. R112 was seated on the edge of her bed calling out "help me, I'm having more bowel movements and I can't get out of the bed, help me." Nursing assistant (NA) was observed to walk by resident	F 758	• R112 PRN medication was immediately reviewed by nursing and the resident's physician and was discontinued. Non-pharmacological interventions were added to R112's care plan. • All residents on a psychotropic medication have the potential to be affected. • All residents on a psychotropic medication will be reviewed for PRN psychotropic medication use and non-pharmacological intervention use prior to administration of PRN. • Education about unnecessary psychotropic medications will be provided to nursing and social service staff regarding PRN medication use and the documentation of non-pharmacological	

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F 758	Continued From page 37 without any interaction. During an interview on 11/28/18, at 1:31 p.m. licensed practical nurse (LPN)-C confirmed R112 had received the PRN Zyprexa on 11/11/18, 11/14/18, 11/16/18 and was unsure if there was documentation indicating non-pharmacological interventions. Registered nurse (RN)-B verified there was no documentation for non-pharmacological interventions used prior to medication being administered and on 11/23/18, 11/24/18, 11/25/18, 11/27/18 and 11/28/18 the medication was also administered. RN-B stated the non-pharmacological documentation would be found in the nurse progress notes. At 2:06 p.m. RN-B stated staff were to offer R112 a snack, call spouse, television prior to medication administration. R112's physician orders included Zyprexa (antipsychotic medication) 5 milligrams (mg) by mouth PRN "(if pt not redirectable)" three times daily and 7.5 mg by mouth two times daily related to unspecified dementia with behavioral disturbances and Trazodone Hydrochloride (anti-depressant) 100 mg by mouth at bedtime for sleep difficulties. During review of the Medication Administration Record for November 2018, it was revealed on 11/4/18, 11/11/18, 11/16/18, 11/23/18, 11/24/18, 11/25/18, 11/27/18, and 11/28/18, R112 had received the PRN Zyprexa however, the medical record lacked documentation of non-pharmacological interventions implemented prior to the medication being administered. During a telephone interview on 11/29/18, at 12:41 p.m. the consultant pharmacist (CP) stated it was his expectation for staff to attempt non-pharmacological interventions prior to medication administration. The CP identified he was not able to locate the non-pharmacological interventions on 11/22/18, however did not	F 758	interventions. • Monthly anti-psychotic meetings will be implemented to review residents receiving anti-psychotic medications. The facility will continue to participate in the CMPRP regarding Dementia Care Breakthrough Community through CMS. • Director of Nursing/Designee will be responsible for conducting audits on PRN psychotropic medication use and non-pharmacological intervention use. Audits will be conducted at 10 residents per week x 3 weeks and reported to QAPI committee for further review and recommendations.	

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F 758	Continued From page 38 include this with his pharmacy recommendation. During an interview on 11/29/18, at 1:57 p.m. RN-B confirmed the care plan was not communicated on the care sheet to the nursing assistants. During an interview on 11/29/18, at 2:48 p.m. the interim director of nursing (DON) stated it was her expectation for non-pharmacological interventions to be attempted and documented in the electronic medical record prior to medication administration. A facility policy related to non-pharmacological interventions prior to antipsychotic medication administration was requested but not received.	F 758		
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. §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	F 761		1/4/19

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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 761	Continued From page 39 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 and interview, the facility failed to ensure medications and biologicals were removed in medication storage areas when expired for 1 of 2 medication rooms and 1 of 4 medication carts. Findings include: The medication storage room on the transitional care unit (TC)U was reviewed 11/29/18, at 01:00 p.m. with LPN-E. There were two mixed intravenous IV bulb containers in the refrigerator of Meropenem 1 gram (Gr)/100 ml normal saline (NS), that had been mixed by the pharmacy 11/16/18 and expired on 11/20/18. Meropenem antibiotic fights severe infections of the skin and stomach. In addition, the medication room on TCU had 3 expired male vial adapters of which one expired on 7/17, another expired 4/17, and a third adapter expired on 10/17. Additional expired supplies were: 2 Y connectors , one expired on 11/13 and and another on 2/14; 1 Insyte Autoguard winged had expired on 6/17. LPN-E confirmed the above expired meds and supplies The medication cart on for (500/800) resident rooms was reviewed on 11/29/18, at 1:35 pm with TMA-A and confirmed that the cart had a Novolog Flex Pen opened that had been opened but not labeled with the date it had been opened.	F 761	• All medication carts and medication rooms were immediately audited for proper medications and supplies and anything expired was disposed of properly. • Each medication room and medication cart have the potential to house expired medications. • All medication carts and medication rooms will continue to be audited for expired medications by both nursing and pharmacy services per facility protocol. • Education will be provided to nursing staff regarding F761 Labeling and Storage of Drugs and Biologicals. • Director of Nursing/Designee will be responsible for conducting audits weekly x5 weekly and then ongoing and reported to QAPI committee for further review and recommendations.	

F5105031

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245105	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**11/29/2018**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (The Estates of Roseville) was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This Estates of Roseville was built in 1965 as a 2-story building without a basement and was determined to be Type II (222) construction. In 1973 a 1-story addition was constructed to the west of the existing building and was determined to be Type II (222) construction. In 1983 a 2 story addition (Woodhill) was constructed to the south of the original building and was determined to be Type II (222) construction. In 1995 a dining room addition was constructed to the south wing of the 1973 addition and was determined to be Type II (222) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 175 beds and had a census of 143 at the time of the survey.	K 000		

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

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

Electronically delivered
December 11, 2018

Administrator
The Estates At Roseville Llc
2727 North Victoria
Roseville, MN 55113

Re: State Nursing Home Licensing Orders - Project Numbers S5105031, H5105142

Dear Administrator:

The above facility was surveyed on November 26, 2018 through November 29, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5105142 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules 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:

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

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
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
	00497	A. BUILDING: ______ B. WING ______	C 11/29/2018

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

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2 000	Continued From page 1	2 000		

Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

On November 26 through November 29, 2018 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.

Complaint #H5105162 was investigated and was not substantiated.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 2 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		
2 445	MN Rule 4658.0220 Freedom from Corporal Punishment & Seclusion A resident must be free from corporal punishment and involuntary seclusion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 residents (R490) were free from involuntary seclusion. Findings include: R490 was admitted to the nursing home on 11/2/18, to the transitional care unit (TCU), with diagnoses that included unspecified dementia without behavioral disturbances. The admission Minimum Data Set dated 11/22/18, identified R490 had a score of 14 on the brief interview for mental status (BIMS), a score of 13-15 indicated a resident was cognitively intact. Review of the medical record indicated R490 was transferred to the Victoria secured unit on 11/5/18. On 11/28/18, at 8:34 a.m. R490 approached the surveyor on the Victoria secured unit and asked for coffee. Staff attempted to re-direct R490 to the dining room and R490 said that he didn't want	2 445	Corrected	1/4/19

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2 445	Continued From page 3	2 445		

to sit down and "stare at the wall". At 8:53 a.m. R490 was observed in the dining room at his table with his back to the door and facing a book case that was up against the wall.

On 11/29/18, at 9:00 a.m. R490 approached the surveyor on the Victoria secured unit. R490 said that he felt like he was in prison and that he can't get past the doors. R490 said that he had not tried to leave, he knew that he could not go back to his home but "getting off the memory care unit" would help. R490 expressed frustration because there was no one to talk to because most of the residents on the unit don't talk. R490 indicated the social worker was assisting him to go to an assisted living facility. R490 said the staff thought he was crazy and they didn't want him to call the unit a prison. R490 asked what would you call it if you can't leave? He told the surveyor that he walked around the Victoria secured unit because if he sat in his room the "walls would close in on me".

Licensed practical nurse (LPN)-C was interviewed on 11/29/18, at 12:55 p.m. LPN-C said R490's significant other came in daily to visit. LPN-C felt that R490 would do better on the Woodhill secured dementia unit because there would be more residents to talk with on that unit. LPN-C said R490 liked to be in his room, he had never made any attempts to leave and did not require any redirection. LPN-C was not sure why R490 was even on the Victoria secured unit.

Registered nurse (RN)-B and licensed social worker (SS)-A were interviewed on 11/29/18, at 1:15 p.m. and identified that R490 was admitted on to the transitional care unit (TCU) and was up at night and went into other resident's rooms and rummaged through other resident's things and

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2 445	Continued From page 4	2 445		

the residents on the TCU unit were frustrated with R490.

SS-A said it was brought up at the interdisciplinary team (IDT) meeting that it was not appropriate for R490 to be on the TCU. SS-A said she and RN-B went to TCU to review R490 and said he could come with them to the secured Victoria unit. SS-A said since R490 has been on the secured Victoria unit, R490 had not gone into other resident's rooms or rummaged through other resident's things.

RN-B said there was a conversation at the IDT meeting and it was presented to RN-B and SS-A by the nurse manager from TCU that R490 was not appropriate for the TCU.

RN-B and SS-A indicated that R490 was fairly independent and that SS-A was working on finding him an assisted living facility to transfer to. Most of R490's days were spent with his significant other and they watched television and walk to the TCU unit and sat in the front lobby. Both RN-B and SS-A said R490 had not tried to leave the secured Victoria unit and neither RN-B and SS-A had any concerns about R490 exit seeking or leaving the facility.

SS-A said that a long term care unit bed (not in the secured unit) would be a better fit for R490 however he currently has a single room on the secure Victoria unit and SS-A felt that R490 would do better in a single room and currently there were no single rooms available on the long term care unit.

SS-A identified that R490 would be better on the other secure dementia unit (Woodhill) because there were more alert and oriented residents

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2 445	Continued From page 5	2 445		

there that R490 could converse with. SS-A said there were only double rooms available on that unit and R490 was not offered to tour that unit or see the room that was available when he was transferred to the Victoria secured unit.

RN-B identified that R490 was definitely at a different level of socialization compared to other residents on the Victoria secured unit and that R490 was not offered any other room options within the facility. Both RN-B and SS-A were not aware that R490 did not want to be on the secured Victoria unit.

RN-B and SS-A identified the criteria for a secured unit included; a resident exhibiting exit seeking behaviors, had a cognitive impairment and/or would benefit from activity programs.

Director of nursing (DON) was interviewed on 11/29/18, at 1:57 p.m. The DON indicated the criteria for placement on a secure dementia unit included a diagnosis of dementia or Alzheimer's and if a resident was at risk for wandering, and if they were at risk to themselves or others. When placing someone on a secured dementia unit there should be a conversation with the family and the resident, the family and resident should tour the area and be involved with the decision to move. The DON identified there would be an elopement risk assessment done for all residents prior to placement on the secured units. The DON said R490 was not an elopement risk and didn't feel that R490 was advanced enough in his dementia to be on the Victoria secure unit and was unsure how R490 ended up on the unit.

RN-C was interviewed on 11/29/18, at 2:17 p.m. RN-C (who worked as an RN on the TCU) indicated that if a resident was rummaging, in

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2 445	Continued From page 6	2 445		

other resident's rooms and depending on their level of dementia, they may be safer on a dementia unit. RN-C said R490 was rummaging and wandering into other resident's rooms while he was on the TCU. RN-C said this information was brought to and IDT meeting and a decision was made from there to move R490 to the Victoria secured unit. RN-C said the TCU had higher functioning residents and the memory unit would be better suited for R490's needs due the wandering and rummaging.

Administrator was interviewed on 11/29/18, on 2:37 p.m. When asked for the criteria for a secured memory care unit the administrator indicated a resident would have a neurocognitive disorder, exhibit signs of exit seeking and benefit from additional programming. The administrator indicated the family would be involved in the decision process.

Review of progress notes identified that R490 was noted to rummage in his own drawers and closet in his room on the TCU, wandered on the TCU but made no attempts to leave and mistakenly went into another TCU resident's room and was easily re-directed. There were no nursing notes to identify a discussion was held in regards to R490 being moved to the Victoria secured unit. R490 was provided a room change form and he signed it himself to change rooms from the TCU to the Victoria secured unit.

Progress note on 11/4/18, at 1:35 a.m. identified R490 was noted to rummage through his drawers and his closet. Denied any pain when asked, no behavioral issues, pleasant with staff, sitting in the lobby having a snack, no exit seeking behaviors, easily re-directed, frequent safety monitoring continues thru (sic) out the shift.

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2 445	Continued From page 7	2 445		

Progress note on 11/4/18, at 9:43 a.m. identified R490 exhibited wandering behaviors on unit, no attempts of exit seeking or leaving unit. Client did enter another client room mistakenly while looking for his own room; easily redirected.

Progress note on 11/5/18, at 1:58 a.m. identified R490 was rummaging around his room, going from one bed to another in his room...no exit seeking, pleasant with staff, no negative behaviors, frequent safety monitoring continues thru out shift.

Progress note on 11/6/18, at 3:34 p.m. identified R490 was adjusting to his new environment well. No wandering/exit seeing observed. There is no nursing note to identify that R490 was transferred to a different unit or why he was transferred.

Progress note on 11/10/18, at 9:23 p.m. during rounds R490 asked staff why he was on this unit as other residents have wandered in the room and does not like it. He further stated that he wanted to go home.

Progress note on 11/18/18, at 9:44 p.m. R490 stated to staff that he felt like a caged animal and that he wished that he could go home.

An Elopement Risk Evaluation assessment dated 11/13/18, was reviewed for R490. The score was 7 (0-14 was no risk). The assessment identified R490 had not history of elopement attempts, was fully ambulatory, accepting of the placement, had disorientation but no wandering, no behaviors noted, was on one antipsychotic medication, and had a diagnosis of dementia. The last question on the assessment read: If at risk for elopement, what prevention measures are being

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2 445	Continued From page 8 implemented and the response was Special Care Unit. The summary and interventions indicated: Resident is not a risk for elopement, placed on secure unit related to dementia. A policy was requested for the criteria for admission to a secured unit. The untitled and undated policy listed memory care criteria: 1. Have a major neurocognitive disorders or show sign and symptoms of major neurocognitive disorders. 2. Patients would typically benefit from increased, specialized programming and/or a controlled access living environment. 3. Qualify for skilled nursing level of care or custodial care where all needs can be met. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents on a locked unit for appropriate consent and indication for admission. The facility could conduct random audits of the residents admitted to the locked unit. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 445		
2 510	MN Rule 4658.0300 Subp. 2 Use of Restraints Subp. 2. Freedom from restraints. Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 510	Corrected	1/4/19

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review, the facility failed to ensure 1 of 1 residents (R43) were free from the use of physical restraints.

Findings include:

R43's admission Minimum Data Set (MDS) dated 9/25/18, indicated R43 was severely cognitively impaired and required extensive assist with bed mobility and transfers. R43's initial care plan dated 9/25/18, identified R43 was at risk for falls related to dementia with behavioral disturbances, required the use of a wheelchair and had impulsive behaviors. Interventions included: bed in lowest position, mattress on floor next to bed as resident was known to crawl out of bed around on the floor while refusing to allow staff to assist to chair. The nursing assistant care guide, identified R43 was a high fall risk and mattress on the floor when in bed related to resident crawling out.

During an observation on 11/29/18, at 7:11 a.m. R43 was lying in bed. The bed was positioned with one side against the wall. R43's wheelchair was at the other side of R43's bed, there was no floor mat noted on the floor beside R43's bed. Bed was noted to be in the lowest position. Nursing assistant (NA)-A assisted R43 with morning cares. R43 was observed to have two pillows on R43's left side. The pillows were tucked under the fitted sheet of the bed. Prior to getting R43 out of bed NA-A took a cushion out from under the mattress. The cushion was approximately two feet long and one foot wide and 6 inches in height. The cushion was labeled "heel management".

While NA-A was assisting R43 to the bathroom for morning cares, licensed practical nurse

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(LPN)-B was in the room. LPN-B indicated R43 had been seen crawling out of bed and scooting on her behind on the floor in her room.

During an interview on 11/29/18, at 7:45 a.m. NA-A indicated that she didn't normally work on this unit and when she did work on the unit, she worked the p.m. shift as a trained medication assistance (TMA). NA-A was not sure if the pillows under the fitted sheet and heel cushion under the mattress were normally there however when she had worked on the p.m. shift in the past she had observed them.

LPN-C was interviewed on 11/29/18, at 7:51 a.m. LPN-C said that R43 used to have a personal alarm on her bed and that was removed. When asked about the heel management cushion, LPN-C said that it was used to off load R43's heels. LPN-C said the floor mat was removed and now the heel cushion was put on the floor so if R43 crawled out of bed she wouldn't land hard on the floor. LPN-C stated that the heel cushion should not be put under the mattress or the pillows put under the fitted sheet if it would prevent R43 from getting out of bed on her own.

Registered nurse (RN)-B was interviewed on 11/29/18, at 7:59 a.m. RN-B said when R43 was first admitted, the facility was using a fall mat and now were conducting a trial without the fall mat. The heel management cushion was used to float R43's heels as a preventative measure. RN-B said it was not typical to tuck the heel cushion under the mattress or the pillows under the fitted sheet. RN-B was not aware how staff were using the cushion or the pillows.

The director of nursing (DON) was interviewed on 11/29/18, at 1:37 p.m. The DON indicated that if a

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2 510	Continued From page 11 resident was able to get out of bed on their own and had pillows underneath the fitted mattress sheet and a heel management cushion under the mattress it would be considered a restraint. A facility policy titled Restraints dated (undated) was reviewed. The policy indicated there would be documentation of consent for the use of a restraint in the resident's medical record with the discussion of risks and benefits along with a physician's order and a "Restraint Assessment" form. R43's record was reviewed, there was no discussion of risks and benefits of the pillows or heel management cushion that were used, no physician's order and no restraint assessment found. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents with restraints for appropriate consent and indication.The facility could conduct random audits of the residents restrained. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 510		
2 835	MN Rule 4658.0520 Subp. 2 A Adequate and Proper Nursing Care; Criteria Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded. This MN Requirement is not met as evidenced by: Based on observation, interview, and document	2 835	Corrected	1/4/19

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review the facility failed to comprehensively assess and implement interventions to reduce pain for 1 of 5 residents (R73) reviewed for pain, failed to ensure dementia services were provided for 1 of 5 (R12) residents, and adjustment needs were identified and behavioral interventions shared with staff for a new resident that exhibited signs and symptoms of restlessness and agitation for 1 of 5 (R487) residents and failed to implement interventions to reduce the risk for fall for 1 of 5 residents (R78) reviewed for falls.

Findings include:

R73 face sheet dated 11/29/18 indicated diagnoses including unspecified pain, low back pain, and joint pain. A nurse practitioner note dated 8/6/18 indicated R73 had a left hip fracture from a recent fall.

R73's significant change minimum data set (MDS) dated 10/11/18 indicated R73 had moderate cognitive impairment, and had pain frequently, sometimes severe, and had no non-pharmalogical interventions identified for pain.
R73's care area assessment dated 10/18/18 indicated R73 reported frequent, severe pain, consideration of recent fracture of the hip.

The Pain Evaluation dated 10/11/18 also indicated frequent severe pain and noted no schedule pain medication or non- pharmalogical interventions for comfort. The assessment noted R73 had 1 as needed dose of Tylenol.

The current care plan dated 10/26/18 indicated R73 had an alteration in comfort related to a fractured hip and gastrointestinal reflux. The care plan directed staff to assess pain and provide

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medication, rest, repositioning, or massage if indicated.

A hospital discharge summary dated 8/29/18 indicated that R73 had been hospitalized from 8/25/18 to 8/29/18 for an altered mental status caused by an overdose of Methadone. Methadone is a narcotic pain medication used to treat severe pain. The discharge summary indicated an interaction with Methadone and a new seizure medication, and included a recommendation to consider a retrial of a non narcotic medication, or a lower dose of Methadone.

The note from the nurse practitioner dated 9/25/18 did not address the recent hospitalization and change in pain medications.

R73 was interviewed on 11/27/18 at 09:20 a.m., and stated he does not get up due to pain, he said that since he came back from the hospital he only takes as needed (prn) over the counter medications. He said he doesn't bother taking them because they do nothing. R73 stated he can't take narcotics. He was observed to be lying in bed on his back, and moved legs and arms freely.

R73 was interviewed on 11/29/18 at 9:30 a.m., and stated his pain is bad today, but didn't tell the nurse because all they do is offer aspirin, and that doesn't help. He stated getting up hurts so he stays in bed, he stated he sometimes had problems sleeping, and sometimes the pain would be gone for several days. He was observed to be lying in bed on his back, and able to independently roll to each side. RN-A came into the room and assessed R73 and agreed she would call the doctor

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2 835	Continued From page 14 for orders. During an interview with RN-D on 11/29/18 at 07:30 a.m. regarding the MDS pain assessment. She stated a significant change MDS was done due to decline and weight loss. She stated the assessment was difficult to complete because of inconsistent reports from R73. She verified that non pharmalogical interventions were not assessed at this time. She stated she was aware of the change in medications for pain since the hospitalization and that R73 does not ask for the prn medication for pain She verified the assessment did not address where the pain occurred, she stated the assessment doesn't balance out the recent change in treatment for pain. Nursing assistant-D was interviewed on 11/29/18 at 9:22 a.m., and stated that R73 sometimes complained of pain in his legs, and will get out of bed with encouragement. She stated she would tell the nurse if he had pain but R73 would refuse to take medication offered. she stated R73 would direct his care and it was important to offer him choices. LPN- D was interviewed on 11/29/18 at 10:00 a.m. and stated R73 sometimes will refuse mediations, and his ain control is pretty good. She stated she asked daily if he had pain and he will tell her. She stated he got up only a couple of times in the past month, and had no complaints of pain when up. RN-A stated in an interview on 11/29/18 at 9:30 a.m., that ongoing pain assessment is done with R73 and the pain level varies, he often refuses medication.	2 835		

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The facility policy for pain management (undated) indicated that the interdisciplinary team should identify causes of pain, and evaluate for non pharmalogical interventions to address pain.

R87's Admission Record identified an admission date of 11/21/18, with diagnoses that included: Dementia with behavioral disturbances, restlessness and agitation. An initial care plan was requested however was not provided. The nursing assistant care resident information sheet identified R487 had multiple hallucinations and behaviors and directed staff to re-approach R487 if refusing cares. The care guide further indicated R487 would sit or lay on the floor, and take objects apart and carry them around.

R487 was observed on 11/26/18, at 12:21 p.m. in the dining room. R487 came up to the surveyor and asked when he could go home. R487 said he ate three times already that day and he was upset because he needed his insulin. R487 was independent and walked through out the secured Victoria unit without the use of any assistive device.

R487 was observed on 11/26/18, throughout the afternoon and early evening walking around the Victoria unit and exit seek. R487 would sit down on chairs by the nursing station for a few minutes then would get back up again. He asked staff and visitors when he could go home and how he could leave the unit. He appeared upset when staff attempted to re-direct him.

R487 was observed on 11/27/18, after breakfast pacing throughout the unit. He looked for his camera and asked staff if they knew where it was. R487 was observed at the exit doors and

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attempted to leave.

Review of facility Progress Notes identified the following:

On 11/23/18, at 4:59 a.m. indicated R487 was up all shift with agitation, pacing up and down the halls, in and out of other resident's rooms, unable to redirect. The note indicated R487 denied any pain when asked and accepted food and fluids. R487 refused PRN (as needed) medications. Agitation escalated with exit seeking and swinging at staff. R487 was in the dining room when writer heard screaming with loud banging, writer observed resident fighting and swinging with no one else present, it almost appeared that he was being punched in the face, his head would jerk and he would throw himself against the wall, R487 then sat on the floor, looked up and said, "leave me alone"....a few minutes later he attempted to leave unit going door to door. R487 managed to open the doors and run down the 400 hallway. He was extremely agitated and was becoming abusive to staff. R487 then proceed to climb up onto the nursing desk on the long term care unit, his gait was unsteady and he almost fell numerous times. He was stating his blood sugar was low but refused a blood sugar check. Due to the potential for harming himself or staff, 911 was called for assistance. When police arrived R487 de-escalated some and did allow a blood sugar and was compliant with taking Olanzapine (antipsychotic medication) PRN, the police escorted R487 back to the Victoria unit where once again he became agitated and was arguing with the police. R487 wanted to go to the hospital but the police were reluctant to send him. Around 4:30 a.m. the Olanzapine had been ineffective. The on call physician was notified of the situation and gave an order for Seroquel (antipsychotic

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medication) 25 mg. The police spend an hour with R487 until he went to sleep.

On 11/23/18, at 10:16 a.m. indicated R487 had behaviors of pacing in the hallway, anxiety, displayed delusional thoughts, hallucinations displayed by picking up things that were not there.

On 11/23/18, at 11:11 a.m. indicated R487 flipped a dining room table over in the doorway of the dining room, barricading himself in the dining area. Staff were able to flip the table back up but R487 tried to push it back down again. Staff were able to get R487 out of the dining area to the hallway. After review of all reported incidents staff called for recommendation from the primary physician. R487 was sent to the hospital on 11/23/18, related to danger to self and others, hallucinations, exit seeking, crying and yelling and aggressive behaviors toward staff.

On 11/23/18, at 8:00 p.m. R487 returned to the facility.

On 11/24/18, at 11:22 a.m. R487 was restless at 7:00 a.m., pacing in the hallway and wandering into other resident's rooms. R487 attempted to sit on other residents and stated "why are you so stupid? Get my bags, I'm getting out of here." R487 was redirected back to his room where environment was quiet but came straight out of his room and continued to pace the unit....Resident is difficult to redirect at times.

On 11/24/18, at 9:20 p.m. R487 was restless and pacing the unit all afternoon and into the evening. Redirection given multiple times

On 11/25/18, at 9:10 p.m. R487 continued to be

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2 835	Continued From page 18 restless and agitated especially after family left in the afternoon. On 11/27/18, at 12:50 p.m. note indicated R487 had been agitated and pacing the unit all morning and afternoon, pounding on the exit doors, rummaging in and out of other resident's rooms, removing their belongings and unable to re-direct. R487 was digging through the garbage cans and throwing everything out of them onto the floor, crawling under the dining room tables and trying to flip the tables over as well as hitting and kicking at the windows trying to get out. When asked what he was looking for R487 said his camera. He then began to feel the sleeve of SS (social services) shirt and stated, "My camera is here, your using the wrong lens give it to me so I can fix it." SS attempted to re-direct R487. Then he grabbed the program manager's hand and explained to her that her fingers were the different lens covers and she needed to sit still to get it covered up." R487 was distressed by his hallucinations and having delusional thoughts. He continued to enter rooms and crawl under the beds trying to lift them up with his back, stating he is going down stairs. Res. then proceeded to pull the call lights out of the wall and unplug the bed remotes. Res. was given a television remote which he believed was his camera and had been holding it up to his eye and trying to take pictures of people by hitting the buttons on the remote. Staff were providing a 1:1 due to impulsive behavior and a risk to himself and others. A subsequent note dated 11/27/18, at 2:16 p.m. indicated social services contacted R487's daughter regarding a bed hold. There were no further progress notes in the record to identify R487 going to the hospital.	2 835		

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Interview on 11/28/18, at 2:25 p.m. registered nurse (RN)-B said that R487 was still at the hospital and the hospital was looking for a place for him. RN-B stated the hospital did want to keep him and because of his dementia was not appropriate for psychiatric services.

Licensed social worker (SS)-A was interviewed on 11/29/18, at 8:40 a.m. SS-A said prior to R487's admission on 11/21/18, R487 was on one to one monitoring at the hospital. SS-A said the facility was told the one to one monitoring was for wandering, not for aggression or hallucinations. SS-A was asked the status of R487 after he was re-admitted to the hospital on 11/27/18. SS-A said that R487 was at the hospital and the hospital was looking to possibly admit R487 to the geriatric psychiatric unit. SS-A thought that R487 was admitted to the hospital and indicated that R487 was on a bed hold.

Nursing assistant (NA)-E was interviewed on 11/29/18, at 10:00 a.m. NA-E was asked about R487 and what interventions were identified for him when he was agitated or upset. NA-E said that staff needed to leave him alone and re-approach later. NA-E said when R487 was upset and wanted to go home, she would tell him that he lived at the nursing home now and he needed to stay on the unit.

Licensed practical nurse (LPN)-C was interviewed on 11/29/18, at 10:14 a.m. LPN-C said the first time she worked with R487 was when he came back from the hospital on 11/23/18 and stated when she worked with R487 she noticed that he was irritated. LPN-C stated she would read his facial expression and would re-approach him if needed. LPN-C worked on the unit on 11/27/18, when R487 went to the

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hospital but stated she was unaware that R487 had pushed over tables in the dining area prior to staff sending him to the hospital.

Family member (FM)-A was interviewed on 11/29/18, at 12:21 p.m. FM-A indicated that she did not get a lot of information from the facility. FM-A stated she would call and ask how R487 slept and staff would tell her that they just started their shift and did not know. When the facility sent R487 to the hospital, FM-A said the facility called and said, "Your dad is misbehaving and we are sending him to the hospital". FM-A was asked if the facility asked her about interventions for R487 to help with his agitation or restlessness and said the facility had never asked her any ideas or suggestions to help R487 with agitation, restlessness or adjustment to the facility.

RN-B and SS-A were interviewed on 11/29/18, at 10:23 a.m. and stated R487 had been on a one to one most of the time that he had been at the nursing home. RN-B and SS-A were aware that R487 was on a one to one at the hospital but thought that was for wandering. The indicated at the facility, R487 was on one to one for wandering, agitation and exit seeking. RN-B said R487 was difficult to re-direct.
When R487 was sent to the hospital on 11/27/18, RN-B said that he was very agitated and looking for his camera. RN-B said activity staff was looking to find a camera. When asked if there were interventions that may work with R487, SS-A said they were aware that R487 like to read the newspaper and liked cameras and stated approaches were used with R487 to re-direct him to look at the newspaper but no attempts were made to find a camera for him to use nor had they asked family to bring one in. SS-A said her communication with the family was to call and ask

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the daughter if she would like the bed to be held when R487 went to the hospital. SS-A stated when R487 returned to the facility the evening of 11/23/18, SS-A was not in the building and then was gone for the weekend and had not had further conversations with the daughter as to what interventions or approaches might work well with R487. SS-A states she was not aware the wife's phone number was listed for R487. (Wife's name and phone number were listed on the admission record sheet as the second emergency contact). SS-A further indicated there had been no direction given to staff on interventions that may be helpful with R487 (newspaper and cameras). SS-A verified there was no direction on the nursing assistant resident information sheet for staff to be aware of or interventions to use with R487. Both RN-B and SS-A acknowledged they could have done a better job getting to know resident and to identify approaches and interventions and inform staff of those approaches and interventions.

The director of nursing (DON) was interviewed on 11/29/18, at 1:37 p.m., and indicated that family was asked upon admission about likes and dislikes and what had worked in the past for residents, and if there were any triggers for behaviors the facility should be aware of. The DON stated typically a 72 hour care management meeting was set up but she was not sure if SS-A had the opportunity to set that up with R487's daughter. She stated if the meeting was not set up and a resident was exhibiting behaviors as R487 had been, the DON would expect staff to call and talk to family about inventions and to try to set up a meeting.

R12's annual Minimum Data Set (MDS) dated

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8/28/18, indicated R12 was severely cognitively impaired and required assistance with all activities of daily living. R12's care plan dated 1/12/18, identified R12 had a self-care performance deficit and directed staff to anticipate needs and encourage him to participate to the fullest extent possible with each interaction. The care plan further identified behaviors regarding wandering, rummaging, exit seeking and pacing and directed staff to provide 1 to 1, redirect, reorient, speak in a calm voice, offer snack or television and take time to talk with him when he appeared not interested in things.

On 11/28/18, at 7:24 a.m. R12 was observed to enter room 926 someone in the room stated "do not come in here" R12 then attempted to enter the unit nurse office; licensed practical nurse (LPN)-C stated "this is my office I am begging you go that way." R12 attempted to exit the unit and sounded the door alarm registered nurse (RN)-B stated "hi buddy" and assisted R12 to turn the opposite direction. R12 entered room 934 and rearranged the dolls a nursing assistant (NA) stated " ...come let's go this way I have some juice for you, let's go this way;" R12 continued to follow NA down the hall and the NA entered the soiled utility room while R12 continued towards the dining room the NA went the opposite direction. At 7:41 a.m. R12 attempted to exit the unit then turned around and entered room 924; upon entrance the resident asked "what does he do if I knew what he did" NA tapped R12 on should and pointed with finger away from door R12 turned around and attempted to exit the unit NA yelled R12's name twice from approximately 10 feet away and R12 turned around.

During an interview on 11/28/18, at 1:26 p.m. NA-E stated R12 walked from room to room

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around the unit and identified telling R12 to come out or move worked to redirect R12.

On 11/28/18, at 1:45 p.m. R12 attempted to open door to the outside then paced in and out of dining room where activity was in progress. Activity assistant did not invite R12 to activity.

On 11/29/18, at 7:09 a.m. R12 attempted to exit unit; nurse walked by and did not intervene then attempted to enter room 924 nurse stated no, no go the other way. At 7:22 a.m. R12 entered room 931; resident in 931 stated "you don't belong here there's nothing here for you now let's go this way" and opened door as R12 exited room. The resident in 931 further stated R12 invaded his privacy and indicated when R12 entered his room he just tells him to leave.

During an interview on 11/29/18, at 8:52 a.m. LPN-C indicated it was normal for R12 to roam the unit and walk into others rooms all day and night. LPN-C stated they told R12 no or please get out of there. LPN-C explained she was unsure if R12 had any activities of interest and further stated R12's son had brought a couch and television for his room however, R12 did not ever watch it.

During an interview on 11/29/18, at 1:50 p.m. RN-B identified R12 liked television and would sit on the chair in his room and watched television for long periods of time and he especially enjoyed old movies. RN-B stated R12's television and movie preference was not written down however, was stated during verbal report. RN-B further indicated R12's preferences should have been added to his care sheet and confirmed it was not currently listed.

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During an interview on 11/29/18, at 2:45 p.m. the interim director of nursing stated it was her expectation not to yell down the hallway to redirect a resident that she would expect the staff would have offered food, fluids and/ or television as a diversion and further identified these preferences should be listed on the care sheet.

A facility policy related to dementia care was requested but not received.

R78 quarterly Minimum Data Set (MDS) dated 10/16/18, indicated she was severely cognitively impaired and required extensive assistance with all activities of daily living. The MDS included R78 required limited assistance for walking and balance was only able to stabilize with human assist. R78's care plan dated 10/26/18, identified R78 was at risk for falls and directed staff to keep extra chair out of residents room to maintain a clutter free environment, observe for unsafe movements, encourage use of walker, low bed, and to wear gripper socks at night.

A review of R78's Fall Review Evaluation dated 10/15/18, indicated she had two falls during past six months and to monitor for increased knee pain and decreased mobility. A review of facility incident reports indicated R78 had a history of falls on 10/2/18, 10/5/18, 10/21/18, 11/6/18, 11/11/18 and 11/21/18.

During an observation on 11/28/18, at 9:45 a.m. R78 was walking in common area without assistance or walker; nursing assistant (NA)-D approached R78 and stated let's go back to your room held R78's left hand and guided R78 back to her room. At 10:10 a.m. R78 was observed walking around her room without walker; NA-D

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guided R78 to her bed and verified R78's bed was able to go low to the floor, however it was supposed to be approximately two to three feet higher than the lowest position when occupied for ease of transfers. At 10:30 a.m. NA-D confirmed R78 did not have her walker within reach and it had been left in the dining room out of R78's reach since breakfast.

During an observation and interview on 11/29/18, at 10:46 a.m. NA-C confirmed R78 was lying in bed and her bed was approximately 3 feet higher than the lowest position, her walker was out of reach near the bathroom door and explained the extra chair in her room was for visitors and was supposed to be there.

During an interview on 11/29/18, at 1:45 p.m. registered nurse (RN)-B stated R78's fall interventions included bed to be in lowest height position, encourage use of walker when walking and no chairs should be left in R78's room. RN-B confirmed R78's fall interventions were not listed on the NA care sheet.

During an interview on 11/29/18, at 2:43 p.m. the interim director of nursing (DON) stated it was her expectation the NA care sheet was updated with current fall interventions to match the care plan.

The facility protocol Falls Prevention and Management Protocol revised date 7/2018, indicated "The purpose of this protocol is to identify resident at risk for falls, implement fall prevention interventions..."

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could review all residents at risk for falls and pain, and

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2 835	Continued From page 26 receiving care for dementia to assure they are receiving the necessary treatment/services to prevent pain. 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.	2 835		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the	21426	Corrected	1/4/19

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facility failed to accurately record the results of tuberculosis(TB) skin tests (TST) for 2 of 3 residents (R57, R134). In addition, the facility failed to accurately complete the Baseline TB Screening Form for 2 of 3 resident (R134, R65).

Findings include:

Review of R65's Admission Record indicated an admission date of 10/2/18. Review of R65's Baseline TB Screening Forms indicated a step one TST was administered on 10/3/18. The form lacked evidence of time read and millimeters of induration (an increase in the fibrous elements in tissue commonly associated with inflammation). Further, R65's symptom screening form lacked a signature and date completed.

Review of R57's Admission Record indicated an admission date of 11/6/18. Review of R57's Baseline TB Screening Form indicated a step one TST was administered on 10/11/18, but lacked a signature and date for the symptom screen.

Review of R134's Admission Record indicated an admission date of 10/10/18. Review of R134's Baseline TB Screening Form dated 11/6/18, indicated the step one TST was administered on 11/7/18, at 7:40 p.m. and read on 11/9/18, at 4:00 p.m. indicating 48 hours had not passed prior to reading the results. In addition, the form lacked documentation of the induration of the results and the date the screening was completed.

On 11/29/18, at 12:55 p.m. during an interview, the interim director of nursing (DON) stated the expectation was the Baseline TB Screening Forms should be thoroughly completed by the nurses. The DON added the nurses were taught how to fill them out during initial orientation. The

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21426	Continued From page 28 DON verified R57's step one Mantoux was read too early and there was no induration documented, and it lacked a signature and date for the symptom screen. R65's symptom screen was missing a signature and date and lacked documentation of the induration on step one of the TST. The DON also verified R134's symptom screening lacked a signature and date and the step one TST was read too early. Review of the facility's Tuberculosis Infection Control Program Policy dated 11/10, indicated the baseline screening for symptoms and risk factor assessment and initial test should be completed within 72 hours of admission. The policy also indicated the reading of each mantoux was to be completed 48 to 72 hours after administration of the Mantoux solution. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review/revise policies and procedures related to tuberculosis baseline screening and could train staff, monitor and assure residents are reviewed for tuberculosis symptoms and screening forms are completed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a	21630		1/4/19

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21630	Continued From page 29 manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to attempt non-pharmacological interventions prior to as needed (PRN) antipsychotic medication administration for 1 of 5 resident (R112) reviewed for unnecessary medications. Findings include: R112's admission Minimum Data Set (MDS) dated 11/6/18, indicated R112 had diagnoses which included dementia, depression and non-traumatic brain dysfunction. In addition, the MDS indicated R112 received antipsychotic and anti-depressant medication for seven days during the reference period. During an observation on 11/28/18, at 7:11 a.m. R112 was seated on the edge of her bed calling out "help me, I'm having more bowel movements and I can't get out of the bed, help me." Nursing	21630	Corrected	

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assistant (NA) was observed to walk by resident without any interaction.
During an interview on 11/28/18, at 1:31 p.m. licensed practical nurse (LPN)-C confirmed R112 had received the PRN Zyprexa on 11/11/18, 11/14/18, 11/16/18 and was unsure if there was documentation indicating non-pharmacological interventions. Registered nurse (RN)-B verified there was no documentation for non-pharmacological interventions used prior to medication being administered and on 11/23/18, 11/24/18, 11/25/18, 11/27/18 and 11/28/18 the medication was also administered. RN-B stated the non-pharmacological documentation would be found in the nurse progress notes. At 2:06 p.m. RN-B stated staff were to offer R112 a snack, call spouse, television prior to medication administration.
R112's physician orders included Zyprexa (antipsychotic medication) 5 milligrams (mg) by mouth PRN "(if pt not redirectable)" three times daily and 7.5 mg by mouth two times daily related to unspecified dementia with behavioral disturbances and Trazodone Hydrochloride (anti-depressant) 100 mg by mouth at bedtime for sleep difficulties. During review of the Medication Administration Record for November 2018, it was revealed on 11/4/18, 11/11/18, 11/16/18, 11/23/18, 11/24/18, 11/25/18, 11/27/18, and 11/28/18, R112 had received the PRN Zyprexa however, the medical record lacked documentation of non-pharmacological interventions implemented prior to the medication being administered.
During a telephone interview on 11/29/18, at 12:41 p.m. the consultant pharmacist (CP) stated it was his expectation for staff to attempt non-pharmacological interventions prior to medication administration. The CP identified he was not able to locate the non-pharmacological interventions on 11/22/18, however did not

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21630	Continued From page 31 include this with his pharmacy recommendation. During an interview on 11/29/18, at 1:57 p.m. RN-B confirmed the care plan was not communicated on the care sheet to the nursing assistants. During an interview on 11/29/18, at 2:48 p.m. the interim director of nursing (DON) stated it was her expectation for non-pharmacological interventions to be attempted and documented in the electronic medical record prior to medication administration. A facility policy related to non-pharmacological interventions prior to antipsychotic medication administration was requested but not received. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of labeling medications properly and discarding expired medications. The DON or designee, along with the pharmacist, could audit medications and supplies on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21630		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the	21830		1/4/19

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21830	Continued From page 32 opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and	21830		

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(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

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21830	Continued From page 34 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide choices related to morning rising routines for 3 of 3 residents (R42, R124, R64) reviewed for choices. Findings include: R42's quarterly Minimum Data Set (MDS) dated 9/25/18, indicated she was severely cognitively impaired, required extensive assist of one staff for bed mobility and transfers and was rarely or never understood. R15's care plan printed on 11/29/18, identified alteration in mobility and directed staff to assist with transfers using a mechanical stand. R124's quarterly MDS dated 11/6/18, indicated she was severely cognitively impaired and required extensive assist of one for bed mobility and transfers. R124's care plan printed on 11/29/18, identified alteration in mobility and directed staff to assist with transfers. R64's quarterly MDS dated 10/9/18, indicated she was severely cognitively impaired and required extensive assist of two for bed mobility and one for transfers. During an observation on 11/28/18, at 7:18 a.m. R64 was up in her wheelchair eyes closed and appeared to be asleep. At 8:14 a.m. R64, R124 and R42 were wheeled by staff to the dining room and seated in front of the table all three residents had their eyes closed and appeared to be asleep; At 9:06 a.m. R64, R124 and R42 were served their breakfast food and drink; staff tapped R124's shoulder and stated it was time to eat.	21830	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00497	A. BUILDING: ______ B. WING ______	C 11/29/2018

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R124 replied "I am so tired." The staff began to offer bites of food to R42 while her eye remained closed and needed verbal encouragement to open her mouth. R64 remained with her eyes closed and did not open her mouth despite staff attempts to tap her as they stated her name. At 9:33 a.m. R64 and R42 were in the dining room, both with eyes closed appearing to be asleep.

During an observation on 11/29/18, at 7:17 a.m. R64 was laying dressed in her bed covered with a blanket. Nursing assistant (NA)-B stated she assisted R64 to get dressed around 6:30 a.m. then R64 told NA-B she was tired so NA-B assisted R64 back to bed.

During an observation and interview on 11/29/18, at 8:23 a.m. NA-B confirmed R42, R124 and R64 were seated in their wheelchairs with their eyes closed and asleep at the dining room table. NA-B stated R124 sometimes will inform staff she wanted to stay in bed and indicated they ask R124 if she was ready to wake up. NA-B stated R42 was at times already awake in the morning and if she was sleeping then they allow her a little extra time and then get her ready for breakfast. NA-B explained R64 at time is "so sleepy" during the morning they dress her and assist her back to bed to rest until breakfast.

During an interview on 11/29/18, at 8:43 a.m. NA-A explained she started with the first resident room number listed on her care sheet when getting residents up and ready for the day. NA-A indicated she would wait until closer to breakfast to get a resident up if they were awake the night before. NA-A verified her care sheet did not indicate resident's preferred wake times.

During an interview on 11/29/18, at 8:59 a.m.

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NA-C identified he went in the order of residents listed on his care sheet when waking residents up to get ready and stated "you need to get them to breakfast." NA-C explained residents who could talk could say no to waking up and some would scream so then you don't force them to wake up and those who don't refuse you wake them up and get them ready for the day.

During an interview on 11/29/18, at 1:34 p.m. with registered nurse (RN)-B and social service (SS)-A; RN-B stated R64 would say "leave me alone" if she did not want to wake up, SS-A stated R124 would also say she was not ready to wake up and further stated R42's spouse wanted her up for every meal. RN-B identified the therapeutic recreation department completed an interview on personal preferences upon admission.

During an interview on 11/29/18, at 2:12 p.m. therapeutic recreation assistant (TR)-A indicated they do ask about resident preferences, however they do not ask about preferred wake times.

A facility policy related to resident choices was requested but not received.

SUGGESTED METHOD OF CORRECTION: Social Service and/or their designee could develop /revise policies for resident choices and educate all facility staff on those policies. The DON and/or designee could conduct resident interviews to ensure resident choices are being honored, reviewed then aduit to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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21845	Continued From page 37	21845		
21845	MN St. Statute 144.651 Subd. 13 Patients & Residents of HC Fac.Bill of Rights Subd. 13. Experimental research. Written, informed consent must be obtained prior to a resident's participation in experimental research. Residents have the right to refuse participation. Both consent and refusal shall be documented in the individual care record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident's resuscitation status order matched the resident's stated request of Cardiopulmonary Resuscitation (CPR) for 1 of 1 residents (R27) reviewed for advance directives. Findings include: R27's diagnoses included atrial fibrillation, chronic obstructive pulmonary disease, angina pectoris, malignant neoplasm of tongue, tracheostomy and acute respiratory failure with hypoxia obtained from the admission record dated 11/28/18. R27's admission Minimum Data Set (MDS) dated 9/18/18, indicated R27 was cognitively intact, was able to make himself understood, and usually understood others. The MDS also indicated it was very important to R27 to have family or a close friend involved in discussions about his care. R27's Physician's Orders for Life Sustaining Treatment (POLST) were reviewed and indicated "Cardiopulmonary Resuscitation" (CPR). R27 signed and dated the POLST on 10/11/18. The	21845	Corrected	1/4/19

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POLST was signed and dated by a nurse practitioner on 10/11/18.

R27's Initial/Comprehensive care plan dated 8/16/18, indicated R27's current code status was Cardiopulmonary Resuscitation (CPR).

R27's Order Summary Report dated 11/28/18, identified and order for DNI/DNR dated 11/21/18, however, the medical record lacked documentation whether a clarification had been obtained to change R27 from a Full code prior to hospitalization.

On 11/28/18, at 8:16 a.m. licensed practical nurse (LPN)-A assigned to R27 stated if she needed to know any resident code status she would look at the orders tab in Point Click Care (PCC) which usually listed the code status on the top. LPN-A verified R27 current listed code status was DNI/DNR.

On 11/28/18, at 9:06 a.m. when asked what his wishes were R27 stated he wanted staff to do CPR if they found him unresponsive.

On 11/28/18, at 9:10 a.m. registered nurse (RN)-A verified the medical records did not matching pertaining to the resident advanced directive. RN-A stated the nurses were supposed to make sure it was addressed. RN-A stated R27 had recently been at the hospital and was re-admitted to the facility on 11/21/18, and at that time staff reviewed and verified the orders. She stated she would have expected them to verify the POLST and orders matched and if not, they were supposed to get a clarification. RN-A reviewed the hospital discharge orders and verified R27's code status was DNI/DNR.

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21845	Continued From page 39 On 11/28/18, at 2:13 p.m. the interim director of nursing stated staff were to follow the policy regarding assessing the code status and stated "when residents come to the facility we ask the nurses to ask the resident their POLST wishes and we go by what the resident wants. When he was re-admitted from the hospital with the DNI/DNR order I would have expected the nurse to have clarified with the resident and in this situation the ball was dropped when he came back. We will start right away to audit." SUGGESTED METHOD OF CORRECTION: Social Service and/or their designee could develop /revise policies for resident choice for cade status and educate all facility staff on those policies. The DON and/or designee could conduct resident interviews to ensure resident choices are being honored, reviewed then aduit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21845		