CENTERS FOR MEDICARE & MEDICAID SERVICES

OTHER

00-Active

07-Provider Status Change

04-Other Reason for Withdrawal

DETERMINATION APPROVAL

30. REMARKS

(L31)

(L33)

					AND TRANSMITTAL TE SURVEY AGENCY	ID: TEQW Facility ID: 00979
1. MEDICARE/MEDICAID PROVIDE (L1) 245264 2.STATE VENDOR OR MEDICAID NO (L2) 176622800		3. NAME AND AD (L3) AUGUSTAN (L4) 14650 GARF (L5) APPLE VAL	A HCC OF AP RETT AVENUE	PPLE VALL	(L6) 55124	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	9/2018 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	09 ESRD 10 NF 11 ICF/IID 12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	178 (L18) 178 (L17)	Compliand 1. A B. Not in Con		gram	And/Or Approved Waivers Of T 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: A	7. Medical Director
14. LTC CERTIFIED BED BREAKDO' 18 SNF 18/19 SNF 178 (L37) (L38)	WN 19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMA 17. SURVEYOR SIGNATURE Eva Loch, Unit Supe		Date :	01/07/2019	(L19)	18. STATE SURVEY AGENCY Douglas Larson, En	APPROVAL Date: Inforcement Specialist 01/08/2018 (L2
19. DETERMINATION OF ELIGIBILI _X 1. Facility is Eligible to I 2. Facility is not Eligible	ГY Participate	20. COM	BY HCFA RI			ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE OF PARTICIPATION 07/01/1983 (L24)	23. LTC AGREEM BEGINNING		4. LTC AGREEM ENDING DAT		01-Merger, Closure 02-Dissatisfaction W/ Reimburser	00 INVOLUNTARY 05-Fail to Meet Health/Safety ment 06-Fail to Meet Agreement
25 LTG EVTENGION DATE	27 ALTERNIATIS	TE CANCELONG			03-Risk of Involuntary Termination	OTHER

(L44)

(L45)

29. INTERMEDIARY/CARRIER NO.

32. DETERMINATION OF APPROVAL DATE

03001

12/03/2018

25. LTC EXTENSION DATE:

28. TERMINATION DATE:

31. RO RECEIPT OF CMS-1539

(L27)

27. ALTERNATIVE SANCTIONS

A. Suspension of Admissions:

B. Rescind Suspension Date:

(L28)

(L32)



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 7, 2019

Administrator Augustana HCC Of Apple Valley 14650 Garrett Avenue Apple Valley, MN 55124

RE: Project Number S5264029

Dear Administrator:

On November 2, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective November 7, 2018. (42 CFR 488.422)
- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 6, 2019. (42 CFR 488.417 (a))

On December 21, 2018, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

• Per instance civil money penalty of \$15,500 for the deficiency cited at F760 (S/S: G), effective October 18, 2018. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on October 18, 2018 that included an investigation of complaint numbers H5264074 and H5264075. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On December 19, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on November 30, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 18, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 29, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 18, 2018, as of November 29, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective November 29, 2018.

Augustana Hcc Of Apple Valley January 7, 2019 Page 2

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of December 21, 2018:

- Per instance civil money penalty will remain in effect. (42 CFR 488.430 through 488.444)
- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 6, 2019 be rescinded as of November 29, 2018. (42 CFR 488.417 (a))

In our letter of November 2, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(l)(b) and 1919(f)(2)(B)(iii)(l)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 25, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 12, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

1 Julius Stapeon

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245264

January 7, 2019

Administrator Augustana Hcc Of Apple Valley 14650 Garrett Avenue Apple Valley, MN 55124

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 November 29, 2018 the above facility is certified for:

178 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 178 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,

Towers Stapeon

Douglas Larson, Enforcement Specialist

Augustana Hcc Of Apple Valley January 7, 2019 Page 2

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL		ID: TEQW
	PARTI	- TO BE COMP	LETED BY T	HE STAT	TE SURVEY AGENCY		Facility ID: 00979
MEDICARE/MEDICAID PROVI (L1) 245264 2.STATE VENDOR OR MEDICAID		3. NAME AND AD (L3) AUGUSTAN (L4) 14650 GARF	A HCC OF AP	PLE VALI		4. TYPE C 1. Initial 3. Termin	DF ACTION: 2 (L8) 2. Recertification nation 4. CHOW
(L2) 176622800		(L5) APPLE VAL	LEY, MN		(L6) 55124	5. Valida 7. On-Sit	
5. EFFECTIVE DATE CHANGE O (L9) 01/25/2006	F OWNERSHIP	7. PROVIDER/SU	PPLIER CATEGO 05 HHA	RY 09 ESRD	02 (L7) 13 PTIP 22 CLIA		rvey After Complaint
6. DATE OF SURVEY 1. 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Ott		02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		AR ENDING DATE: (L35) 9/30
11LTC PERIOD OF CERTIFICAT		10.THE FACILITY	IS CERTIFIED AS	ζ.			
From (a): To (b):		A. In Complia Program F Complian	Requirements ce Based On:		And/Or Approved Waivers Of T2. Technical Personnel3. 24 Hour RN	_ 6. S _ 7. N	Scope of Services Limit Medical Director
12.Total Facility Beds	178 (L18)	1. /	Acceptable POC		4. 7-Day RN (Rural SN 5. Life Safety Code	_	Patient Room Size Beds/Room
13.Total Certified Beds	178 (L17)	X B. Not in Cor	mpliance with Progrand/or Applied Wai			(L12)	Seas/Room
14. LTC CERTIFIED BED BREAK	DOWN	Requirements	and/or Applied wal	ivers:	* Code: B * 15. FACILITY MEETS	(L12)	
18 SNF 18/19 S	NF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(I	L15)
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY RE	MARKS (IF APPLICABL	E SHOW LTC CANCE	ELLATION DATE):			
17. SURVEYOR SIGNATURE		Date:			18. STATE SURVEY AGENCY	APPROVAL	Date:
Jodie Fox, HFE NE	E II		11/19/2018	(L19)	Douglas Larson, Enforcement Specialist 11/30/2018		
	PART II - TO BE	COMPLETED	BY HCFA RE	EGIONAI	OFFICE OR SINGLE ST	TATE AGEN	CY
19. DETERMINATION OF ELIGIE	BILITY		MPLIANCE WITH	CIVIL	21. 1. Statement of Fina		
1. Facility is Eligible	to Participate	RIO	GHTS ACT:		 Ownership/Contr Both of the Abov 		ure Stmt (HCFA-1513)
2. Facility is not Eli	gible (L21)						
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEM	IENT	26. TERMINATION ACTION:		(L30)
OF PARTICIPATION 07/01/1983	BEGINNING	DATE	ENDING DAT	E	VOLUNTARY 01-Merger, Closure		INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursen		06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATION A. Suspension	VE SANCTIONS n of Admissions:	(L44)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	<u>.</u>	OTHER 07-Provider Status Change 00-Active
(L27)	B. Rescind Sus	pension Date:	, ,				
28. TERMINATION DATE:	29	. INTERMEDIARY/O	(L45) CARRIER NO.		30. REMARKS		

(L31)

(L33)

DETERMINATION APPROVAL

03001

32. DETERMINATION OF APPROVAL DATE

(L28)

(L32)

31. RO RECEIPT OF CMS-1539



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 2, 2018

Administrator Augustana Hcc Of Apple Valley 14650 Garrett Avenue Apple Valley, MN 55124

RE: Project Numbers S5264029, H5264074, and H5264075

Dear Administrator:

On October 18, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the October 18, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5264074 and H5264075. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this department has recommended and CMS has authorized us to notify you this Department is imposing the following remedy:

• State Monitoring effective October 23, 2018. (42 CFR 488.422)

This Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedies and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 6, 2019.
- Civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 6, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 6, 2019.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction.

The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by January 6, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Augustana Hcc Of Apple Valley will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 6, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "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 their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human

Services that your provider agreement be terminated by April 18, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

PRINTED: 11/26/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245264	B. WING _		C 10/18/2018	
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124	1 10	710/2010
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00		
F 000	Emergency Prepare conducted on 10/18 during a recertificat compliance with the Preparedness Req		F 00	00		
	survey was comple Minnesota Departm your facility was in requirements of 42	gh 10/18/18, a standard ted at your facility by the nent of Health to determine if compliance with the CFR Part 483, Subpart B, for Long Term Care Facilities.				
	as your allegation of Department's accepenrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required it first page of the CMS-2567 ic submission of the POC will tion of compliance.				
	an on-site revisit of conducted to valida	acceptable electronic POC, your facility may be ate that substantial compliance is has been attained in our verification.				
	H5264075 were co substantiated and cand F760.	complaint's H5264074 and mpleted. The complaints were deficiencies were cited at F744 in Meds-Clinically Approp	F 58	54		11/29/18
		· / ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 11/12/2018

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 A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245264	B. WING			C 10/18/2018	
	PROVIDER OR SUPPLIER TANA HCC OF APPLE		STREET ADDRESS, CITY, STATE, Z 14650 GARRETT AVENUE APPLE VALLEY, MN 55124				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 554	§483.10(c)(7) The medications if the defined by §483.2 this practice is clin This REQUIREME by: Based on observareview, the facility resident unable to (SAM) for 1 of 1 reself-administer an Findings include: On 10/15/18, at 12 in her room with a nebulizer (neb) trepresent in the room The registered nurseated in the nurse position to observed observed to enterneb machine and resident (SAM) for 1 of 1 reself-administer and research in the room The registered nurseated in the nurse position to observed observed to enterneb machine and resident (SAM) for 10/16/18, included: DuoNeb six hours as needed exacerbation. R447's care plan of R447's medication.	right to self-administer interdisciplinary team, as 1(b)(2)(ii), has determined that ically appropriate. NT is not met as evidenced ation, interview and document failed to ensure supervision of self-administer medications sident (R447) observed to ebulizer (inhalant medication). 2:57 p.m. R447 was observed face mask on receiving a atment. There was no staff in and/ or down the hallway. Se (RN)-E was observed to effice and was not in the R447. At 1:06 p.m. RN-E was R447's room, turned off the removed R447's face mask. Otes were reviewed; a note dicated R447 was cognitively order report dated 10/17/18, Solution for nebulization every	F 5	554	Immediate Plan of Correction: Identified nurse was individually re-educated to facility policy on self-administration of medications. It was discharged on 11/3/18. Identification of Other Residents: All residents with nebulizer orders in been reviewed to see if they are appropriate to self-administer their nebulizer. Additionally, we reviewed determine if other medications were self-administered without an assess or order. If they were, a self-administration of medication observation has been completed an have obtained orders from the provi indicated. Care plans for those res self-administering medications have updated to reflect ability to self-adm medications. Measures Put in Place: Education will be completed with lic staff regarding the self-administration medication policy. Monitoring Mechanisms: Audits will be completed of 5 reside per week X 3 months to assure appropriate self- administration of medication observation, orders and	d to being sment and we ider as sidents been ninister sensed on of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245264	B. WING_			C 18/2018	
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CO 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 554	did not wish to exe self-administer med RN-E stated that yo able to self-administeaching had been observed. RN-E indocumented in the self-administration would also be com During an interview RN-F, unit nurse mot have an order f RN-F further review and verified that Raindicated R447 was medications. On 10/18/18, at 10 (DON) stated it was observation be con DON further indicated deemed unable to expectation the nur while administering. The facility policy S Medications dated resident wishes to complete the applic form in the EHR. "When a nebulizer tresident and the retreatment running,	rcise her right to dications. on 10/15/18, at 2:35 p.m. ou know when a resident was ster medications after the done and the resident was dicated the teaching would be nurse progress notes and a of medication consent form pleted. on 10/15/18, at 3:44 p.m. anager, indicated R447 did for SAM of neb treatment. wed R447's SAM observation as not able to self-administer as a.m. the director of nursing sher expectation that a SAM appleted for all residents. The ted that if the resident was SAM it would be her se would remain present all medication. belf Administration of 7/25/18, included: "3. If the self-administer medications, cable observation/ assessment The policy further noted "12. reatment is set up for the sident is left alone with the that is considered of medications and the above	F 58	plan are in place if resident self-administering any medi Results of audits will be rev facility SQAPI committee a audits will be recommended indicated. Person responsible for com Director of nursing or desig responsible for compliance.	ications. viewed by the and further d by them as appliance:		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION IG	СОМ	(X3) DATE SURVEY COMPLETED	
		245264	B. WING_		C 10/18/2018		
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 558 SS=D	Needs/Preferences CFR(s): 483.10(e)(§483.10(e)(3) The services in the facil accommodation of preferences except endanger the health other residents. This REQUIREMENT by: Based on observation review, the facility for was within reach for Findings include: During observation was sitting up in health where her call light she did not know work time. The call light she did not know work the time. The call light she did not know work the time was behind for in between the tank stated there were the sasistance to go to but was not able to light was not placed 3:39 p.m. Licensed notified of R30 need LPN-A entered the like you didn't get you the call light was not light and handed it	right to reside and receive ity with reasonable resident needs and when to do so would he or safety of the resident or NT is not met as evidenced tion, interview and document ailed to ensure the call light or 1 of 2 residents (R30). on 10/15/18 at 3:00 p.m. R30 or wheelchair next to her bed. R30 stated she did not know was located. R30 also stated there her call light was most of ght was noted wrapped to and with the bedside table of and the bed. Resident also mes she needed help with the bathroom or use bedpan, call for help because the call did within reach. On 10/15/18 at Practical Nurse (LPN-A) was ding assistance. At 3:44 p.m. room and told R30 "It looks our call light", LPN-A verified of within reach, moved the call	F 55	Immediate Plan of Correction: Call light was given to R30 on 10 when notified that call light was reach. Identification of Other Residents Nursing leadership staff audited residents to ensure call lights we reach on 10/18/18. Measures Put in Place: Education completed with all staregarding proper placement of completed with all staregarding proper placement of complete to the position of audits will be by the facility staff will audit 10 rooms X 3 months to ensure call lights reach. Results of audits will be by the facility SQAPI committed further audits will be recommend them as indicated. Person responsible for complian Director of nursing is responsible compliance.	not in all all lights. per week are in reviewed e and ded by	11/29/18	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED		
		245264	B. WING	i		1	C 18/2018
	PROVIDER OR SUPPLIER	VALLEY	1	<i> </i>	STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124	101	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 558	diagnoses including weakness. R30's Care plan da was non ambulator toileting, mobility, a was alert and orien light within reach". R30's Care Area As R30 was at risk for ADL's and staff to a reach at all times w On 10/18/18 at 1:18 (RN-C) also nurse is stated residents ca placed within reach The facility's call ligindicated call lights be accessible to the light should be sect of the resident. Self-Determination CFR(s): 483.10(f)(1) §483.10(f) Self-determination can be seed on the resident of the resident has the promote and facilitate through support of	ted 7/16/18 identified R30 y; required assist with ctivities of daily living. R30 ted, R30 needed to have "call sessment 8/2/18 indicated falls, required assist with assure call light was within while in room. B p.m. the registered nurse manager was interviewed and Il lights were expected to be "at all times". ht response policy dated 3/17, were to be placed so it would be resident at all times, the call call ured to stay within the access and 1)-(3)(8) ermination. The right to and the facility must after resident self-determination resident choice, including but ghts specified in paragraphs (f)	F!	558 561			11/29/18
	activities, schedule waking times), heal	esident has a right to choose s (including sleeping and lth care and providers of s consistent with his or her					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		245264	B. WING		C 10/18/2018	
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION	
F 561	other applicable pro §483.10(f)(2) The rechoices about asper facility that are sign §483.10(f)(3) The rewith members of the incommunity activities the facility. §483.10(f)(8) The reparticipate in other religious, and comminterfere with the rigitacility. This REQUIREMED by: Based on observative review, the facility f(R114) preferences to to the incommunity activities as the incommunity and interview review, the facility for the incommunity and interview results and interview re	ents, and plan of care and ovisions of this part. esident has a right to make ects of his or her life in the difficant to the resident. esident has a right to interact e community and participate ties both inside and outside esident has a right to activities, including social, munity activities that do not gots of other residents in the entry is not met as evidenced ation, interview and document failed to honor 1 of 6 residents for hours of sleep and no were reviewed for on 10/15/18, at 4:39 p.m., goth she preferred to go to bed the evenings staff assisted her to	F 56	Immediate plan of correction: NA assignments were changed so tha NAR caring for R114 stays until 11 which allows for time for R114 to suntil 10pm per her preference. Notes assignment sheet was updated to staff offer R114 the bedpan each subject to the staff interviewed all residents to entheir preferences for toileting and the staff of the staff of the staff interviewed all residents to entheir preferences for toileting and the staff of the st	t the pm tay up AR have hift. acility esure	
	she watched televitime. R114 also stanap after lunch and 10 p.m She enjoy the in the evening. bed" because staff	ly as 8:00 p.m. R114 explained sion programs during this ted that she took a three-hour I was not normally tired before ed working on her computer in R114 felt "rushed to go to were sometimes scheduled ft. R114 said when staff were		are being honored. Measures put in place: Nursing statement were re-educated on the important asking residents about their prefer before providing cares and the importance of honoring those preferences.	ce of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245264	B. WING	_		C 10/18/2018	
	PROVIDER OR SUPPLIER			14	IREET ADDRESS, CITY, STATE, ZIP CODE 4650 GARRETT AVENUE PPLE VALLEY, MN 55124	10/1	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 561	do oral care, wash around 8:00 p.m \ either sat in her wh into bed as early as also stated she warbowel movements, encouraged her to brief. R114 said the use the bedpan, shand and to go in the "That was hard to trincontinent of bowe take time to allow his she was already in "normal" for her to pad. She further exand not good for her During an interview nursing assistant (Nended at 10:00 p.m preferred to stay up explained on the existence and not good for her she talked to her all her preferred bedtin not mind." She furthallowed to work a from 10:00 p.m. she would not mind. She furthallowed to work a from 10:00 p.m. she would not mind. She furthallowed to work a from 10:00 p.m. she would not mind. She furthallowed to work a from 10:00 p.m. she would not mind. She furthallowed to work a from 10:00 p.m. she would not mind. She furthallowed to work a from 10:00 p.m. she would not mind. She furthallowed to work a from 10:00 p.m. she would not mind. She furthallowed to work a from 10:00 p.m. she would not mind. She furthallowed to work a from 10:00 p.m. she would not mind. She furthallowed to work a from 10:00 p.m. she would not mind. She furthallowed to work a from 10:00 p.m. she would not mind. She furthallowed to work a from 10:00 p.m. she would not mind. She furthallowed to work a from 10:00 p.m. she would not mind. She furthallowed to work a from 10:00 p.m. she would not mind. She furthallowed to work a from 10:00 p.m. she would not mind. She furthallowed to work a from 10:00 p.m. she would not mind. She furthallowed to work a from 10:00 p.m. she work and 10:00 p	early they encouraged her to up and put her night gown on When this happened, R114 eelchair for two hours or went is 8:00 p.m. to watch TV. R114 inted to use a bedpan for however, staff often defecate in her incontinent elast time she requested to be was told she had a pad on that if she wanted. R114 stated, ake." R114 stated she was not el and felt staff did not want to the new to use the bedpan unless bed. R114 also said it was have a bowel movement in her explained it was uncomfortable er skin. You no 10/16/18, at 3:15 p.m., the NA)-F stated her shift usually the nutil 10:00 p.m. and wenings she cared for R114, bout going to bed earlier than the and "sometimes she did her explained she was not call shift and if she stayed past all get "late points." 10 p.m., R114 was interviewed did she did not want to go to 0:00 p.m.) and did not want to on at 8:00 p.m. and sit in her lid not want staff to interrupt R114 explained staff was rences because it was	F 5	561	Monitoring mechanisms: All reside asked if their preferences are being during care conferences. Random will be completed of 15 residents p month X 3 months to confirm that t preferences are being honored. Rof these audits will be reviewed by facility's QAPI committee and addit audits will be recommended by the indicated. Person responsible for compliance Director of nursing is responsible for compliance.	g met n audits er heir esults the tional em if	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION	CON	(X3) DATE SURVEY COMPLETED		
		245264	B. WING		l l	C / 18/2018		
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CO 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		110/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 561	said she expected all residents. When shortened shift, she assist R114 to bed RN-B further was a hours of sleep but we consistently honore should be allowed to preferred and that splan and honor R12 On 10/16/18 at 3:58 NA-F stated when I put on the bedpan. On 10/17/18, at 12: R114 "goes in her pon the bedpan. He used the bed pan recent issues with I assistance with toile provide incontinent of bower recent issues with I assistance with toile provide incontinent times a day and as was in place related. The Minimum Data Customary Routine indicated it was "vechoose her own be R114 was frequent."	7 p.m., a registered RN-B staff to follow the care plan of a staff was scheduled for a expected another staff to as her care plan indicated. It was not aware this was not ed. RN-B further stated R114 to use the toileting method she staff should follow the care	F 5	61				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245264	B. WING			1	C 18/2018
	PROVIDER OR SUPPLIER	VALLEY		14	TREET ADDRESS, CITY, STATE, ZIP CODE 1650 GARRETT AVENUE PPLE VALLEY, MN 55124	107	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 561	R114 had no memore mental status and F The Augustana Cardated 10/2/18, note p.m. and indicated bowel and required further direction regchoices were address. R114's Care Plan re R114 preferred to gpreferred not to get 10:00 p.m., and directly pan for bowel move it. During an interview Interim Director of I cares and assistant provided as their caresidents residents possible. The Augustana Cardignity, Choices and 4/16 indicated: It is residents will be treat all times. The faplace to honor residents preferences per plataccommodation. Repreferences will be at quarterly care cowill be care planned choices and preferences and prefere	18, and 9/25/18 indicated by loss or acute changes in R114 had intact. The Health and Group Sheet at R114's bedtime was 10:00 R114 was incontinent of assistance of two staff. No garding toileting needs or essed. Evised 10/2/18, indicated to to bed at 10:00 p.m. She ready for bed earlier than ected staff not to use the bedtements unless she asked for an indicated and as preferred/chose, when the Policy: Observing Resident of Preferences, effective date the standard of care that all stated with respect and dignity cility will also put protocols in	F 5	61			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245264	B. WING				C 1 18/2018	
	PROVIDER OR SUPPLIER			14650	ET ADDRESS, CITY, STATE, ZIP CODE O GARRETT AVENUE LE VALLEY, MN 55124	1 10/	10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 561	benefits review will documented if need encouraged to voice	with the resident and a risk to be completed and ded. Residents will be their concerns and needs at their needs, choices and	F 5	561				
F 577 SS=C	Right to Survey Re CFR(s): 483.10(g)(§483.10(g)(10) The (i) Examine the res of the facility condusurveyors and any respect to the facili (ii) Receive informaclient advocates, at to contact these ag §483.10(g)(11) The (i) Post in a place rand family member	e resident has the right to- ults of the most recent survey acted by Federal or State plan of correction in effect with ty; and ation from agencies acting as and be afforded the opportunity encies.	F 5	577			11/29/18	
	the facility. (ii) Have reports wincertifications, and or respecting the facility years, and any plan respect to the facilition review upon requiring in post notice of the facility accessible to the positive facility of the facility of t	th respect to any surveys, complaint investigations made ity during the 3 preceding of correction in effect with ty, available for any individual uest; and the availability of such reports ity that are prominent and						

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X1) PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245264	B. WING		1	C 18/2018
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124	100	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 577	review, the facility favailability of previous Agency survey result affect all 161 resided visitors and staff whinformation. Findings include: On 10/18/18, at 9:2 dated 12/4/17, were next to the bulletin floor elevator. No nyears survey result the holder or the bulletin floor elevator of three years survey 10:01 a.m. the 2nd survey results or not three years survey 10:01 a.m. the 2nd survey results date from the elevator. It results were availal was no notice of avyears of survey results was no sign if previous years survey there was no sign if previous three years she had not been a survey results were residents and visited location of previous across from the elevators affect the survey results were residents and visited location of previous across from the elevators.	tion, interview and document failed to post notice of pus three years of State falls. This had the potential to ents residing in the facility, no wished to review this 26 a.m. the survey results a observed in plastic holder board across from the first ote regarding previous three is location was observed on alletin board next to the holder. 29 a.m. the Interim Director of ified no previous three years of availability of previous results were on 1st floor. At floor was observed. The id 12/4/17, was posted across DON verified only survey ole for review, however there wailability of the previous three ults. At 10:02 a.m. the 3rd with IDON. IDON verified only vey results were posted, and indicating the availability of the res survey results. IDON stated aware the previous three year at to be made available to the ors. IDON verified no note of a surveys on the bulletin board evator, or on the units.	F 57	Immediate Plan of Correction: A sign was created and posted survey results explaining that the years of survey results are available the receptionist desk. A 3-ring be created with the last 3 years of results, certifications, and complinity investigations and any plans of that are in place. This is available receptionist desk. Identification of Other Residents other residents involved. Measures Put in Place: A sign created and posted by the survexplaining that the last 3 years results are available at the recedesk. A 3-ring binder was creat last 3 years of survey results, certifications, and complaint investigations and any plans of that are in place. This is available receptionist desk. Monitoring Mechanisms: A desifacility staff will confirm once per 3 months that this sign and the binder are still in place and is upperson responsible for complian Business office manager is resifor compliance.	le last 3 lable at binder was survey blaint correction ble at the s: No was ey results of survey ptionist ed with the correction ble at the gnated er month X 3-ring pdated. nce:	
	The facility Survey	Results Posting policy dated				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245264	B. WING	_		l	C 18/2018
	PROVIDER OR SUPPLIER ANA HCC OF APPLE			S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE 4650 GARRETT AVENUE PPLE VALLEY, MN 55124	107	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 577	availability of three results in prominen facility to the public	he facility would post notice of preceding years of survey t and accessible areas of the	F 5				11/29/18
SS=D	S483.10(c)(6) The discontinue treatment to participate in exprormulate an advantage s483.10(c)(8) Noth be construed as the receive the provision	6)(8)(g)(12)(i)-(v) right to request, refuse, and/or ent, to participate in or refuse perimental research, and to	FS	110			11/29/10
	requirements speci subpart I (Advance (i) These requirements inform and provide residents concerning medical or surgical resident's option, for (ii) This includes a stacility's policies to and applicable Stat (iii) Facilities are perentities to furnish the legally responsible requirements of this (iv) If an adult indivitime of admission as information or articles are executed an acceptance of the support of	ents include provisions to written information to all adult and the right to accept or refuse treatment and, at the formulate an advance directive, written description of the implement advance directives to law. Example to contract with other his information but are still for ensuring that the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245264	B. WING		C 10/18/2018	
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION	
F 578	individual's resident with State Law. (v) The facility is not provide this information to the information the information to t	trepresentative in accordance of relieved of its obligation to ation to the individual once he believe such information. The must be in place to provide the individual directly at the of the individual directly at the of the accordance of the individual directly at the of the individual directly at the of the individual directly at the of the residents were accurately so for the residents medical esidents wishes would be only in an emergency situation (R58) reviewed for advanced of the individual of the individ	F 578	Immediate Plan of Correction: The POLST, MD order for code state and face sheet on R58 were update immediately on October 16, 2018. Identification of Other Residents: An audit was completed on 11/12/2 ensure that all code status orders, and face sheets match. Measures Put in Place: Health information and nursing state been educated on the updated policelated to POLST form implementate which was revised and updated on 11/7/18. Health information staff his been re-educated on the important following up on orders that need to clarified, so they are not left as open ended orders. Monitoring Mechanisms: A random sample of 20% of reside charts will be audited one time per X 3 months to confirm that the cod status order, POLST and face sheet information match related to code status of the audits will be review.	ed 18 to POLST ff have icy stion ave ce of be en nt month e et status.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION 3	COM	(X3) DATE SURVEY COMPLETED	
		245264	B. WING			C 18/2018
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 578	comfort cares see I note indicating "Aw Verification (DC Da There was another start date 8/2/18, noted to a start date 8/2/18, noted and indicated and indic	s: DNI/DNI [do not intubate] POLST". There was also a aiting DC [discontinuation] Ite 8/2/18). order open ended order with oting "Code Status: Full ing "Awaiting Verification". order from 8/14/18, also atus: Full Code- CLARIFY". ence in R58's medical record between the POLST, sician's orders were verified 23 a.m. registered Nurse R58's code status in the record (EMR) did not match R58's POLST. RN-B explained uld have given the POLST to nator (HUC) to update R58's chart. 25 a.m. licensed practical red she preferred looking in a resident's code status as it and the code status could also	F 578	the facility square QAPI committees will make recommendations for monitoring as indicated. Person responsible for complia Health information director is refor compliance.	r further	

PRINTED: 11/26/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245264	B. WING	_			0
NAME OF F	PROVIDER OR SUPPLIER	243204	D. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	10/	18/2018
AUGUST	ANA HCC OF APPLE	VALLEY			4650 GARRETT AVENUE		
				A	PPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPLICATION OF T		BE	(X5) COMPLETION DATE
F 578	The facility's Physic Treatment (POLST indicated "8. Socia document in the res resident has a Hea	sian Order for Life Sustaining) policy dated 06/21/2018, Il Services or designee will sident medical record if the Ith Care Directive. This is also Sheet of the resident's	F 5	578			
F 688 SS=D	CFR(s): 483.25(c)(§483.25(c) Mobility		F 6	888			11/29/18
	resident who enters range of motion do range of motion unl	s the facility without limited es not experience reduction in less the resident's clinical ates that a reduction in range					
	motion receives ap services to increase	sident with limited range of propriate treatment and e range of motion and/or to rease in range of motion.					
	receives appropriat assistance to maint the maximum pract reduction in mobility unavoidable.	sident with limited mobility te services, equipment, and tain or improve mobility with ticable independence unless a ty is demonstrably NT is not met as evidenced					
	Based on observative review, the facility f	tion, interview and document ailed to provide restorative residents (R85, R114) litation.			Immediate Plan of Correction: Education was provided to staff that restorative programs need to be completed. If they are unable to cothe exercises or the resident refuse are to notify the nurse.	mplete	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		245264	B. WING			10/1	C 8/2018	
	PROVIDER OR SUPPLIER TANA HCC OF APPLE	VALLEY		14	TREET ADDRESS, CITY, STATE, ZIP CODE 4650 GARRETT AVENUE PPLE VALLEY, MN 55124			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 688	R85's quarterly Mir 9/11/18, indicated I needed limited star walking in room and (meaning not assed change MDS dated needed limited star walked in her room supervision. R85's careplan dat staff were to walk I walker two times of physical therapy and the was supposed to go "almost always" was supposed to go "almost always" was 85 stated nursing her he was "too bushe was "going door R85 stated she wadown the hall as fa and the distance kowas also attending exercises. On 10/17/18, at 1:0 (RN)-A stated R85 for walking and also stated R85 was do therapy had gotten Review of R85's Podated 9/1/18-10/18 documented "Not I for the was "so the stated R85 and gotten Review of R85's Podated 9/1/18-10/18 documented "Not I for the walking and gotten Review of R85's Podated 9/1/18-10/18 documented "Not I for the walking and gotten Review of R85's Podated 9/1/18-10/18 documented "Not I for the walking and gotten Review of R85's Podated 9/1/18-10/18 documented "Not I for the walking and gotten Review of R85's Podated 9/1/18-10/18 documented "Not I for the walking and gotten Review of R85's Podated 9/1/18-10/18 documented "Not I for the walking and gotten Review of R85's Podated 9/1/18-10/18 documented "Not I for the walking and gotten Review of R85's Podated 9/1/18-10/18 documented "Not I for the walking and gotten Review of R85's Podated 9/1/18-10/18 documented "Not I for the walking and gotten Review of R85's Podated 9/1/18-10/18 documented "Not I for the walking and gotten Review of R85's Podated 9/1/18-10/18 documented "Not I for the walking and gotten Review of R85's Podated 9/1/18-10/18 documented "Not I for the walking and gotten Review of R85's Podated 9/1/18-10/18 documented "Not I for the walking and gotten R85's Podated 9/1/18-10/18 documented "Not I for the walking and gotten R85's Podated 9/1/18-10/18 documented "Not I for the walking and gotten R85's Podated 9/1/18-10/18 documented "Not I for the walking and gotten R85's Podated 9/1/18-10/18 documented "Not I for the walking and gotten R85's Podated 9/1/18-10/18	nimum Data Set (MDS) dated R85's cognition was intact, ff assistance to transfer and do corridor was marked as a"-" ssed). R85's significant d 6/18/18, indicated R85 ff assistance with transfers and a and in the corridor with staff and in the corridor with staff and in the hallway using ally to maintain gains made in and R85 ambulated 15-30 feet. 1:23 a.m. R85 told surveyor she get walked two times a day but as not walked in the mornings. It is a sasistant (NA)-C would tell sy" to walk her. R85 stated with hill" from not being walked. It is supposed to be walked at as she could go twice a day ept track of. R85 stated she at therapy for strengthening. 101 p.m. registered nurse was on a restorative program to attended therapy. RN-A sing a lot better now since a R85 up and walking. 115 p.m. registered nurse was on a restorative program to attended therapy. RN-A sing a lot better now since a R85 up and walking. 116 p.m. registered nurse was on a restorative program to attended therapy. RN-A sing a lot better now since a R85 up and walking.	F6	888	Identification of Other Residents: An audit of point of care charting reto restorative nursing programs was completed on 11/12/18 to identify an other residents where staff were eith not documenting or not completing restorative nursing program as ordered. Measures Put in Place: Policy on range of motion was revising 11/7/18. Nursing staff were educate the importance of completing restornursing programs as ordered. Monitoring Mechanisms: Clinical managers will audit complete restorative nursing programs on all residents in the building twice per will audits will be reviewed by the QAPI committee and further monitoring will recommended by them as indicated. Person responsible for compliance: Director of nursing is responsible for compliance.	s ny her the ered. sed on ed on rative tion of sea and of lill be d.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245264	B. WING			I	C 18/2018
	PROVIDER OR SUPPLIER	VALLEY		1	STREET ADDRESS, CITY, STATE, ZIP CODE 4650 GARRETT AVENUE APPLE VALLEY, MN 55124	101	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	On 10/18/18, at 12: weakness in her leg own, and could now looked at the Point computer from 10/1 stated it looked like every morning. Bas been completed thr "Not Performed" fiv "unanswered" ten ti walking was a part program to be compand had been unaw walked every morning. On 10/18/18, at 12: a walking program morning as far as s NA-G stated R85 si had improved with refused to walk. NA walk in her room wi and from the bathrowheelchair for furth room. On 10/18/18, at 1:3 on a walking progradays 50 feet or mor walk R85 in the modo that when less the told the nurses vand the nurses repl NA-C stated R85," rarely, she would have	ge 16 24 p.m. RN-B stated R85 had gs, wanted to walk on her walk short distances. RN-B of Care documentation on the 0/18, through 10/18/18, and R85 was not being walked ged on data walking had only gee times (times), documented get imes, and documented get imes, and documented graph of R85's rehabilitation pleted by the NAs. RN-B stated of R85's rehabilitation pleted by the NAs twice a day ware R85 was not being graph ing and/or afternoon. 47 p.m. NA-G stated R85 had and would walk R85 in the he could walk and document. It is months ago could not walk, therapy and had never walker independently to bom, but needed her er distances like to the dining. 1 p.m. NA-C stated R85 was am and could walk on some get. NA-C stated he tried to rnings but could not always man full staffed. NA-C stated when he could not walk R85 y were, "try to get it done." did not refuse at all to walk, ave to be sick" to refuse. 0 p.m. Interim Director of	F	888			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245264	B. WING			1	C 18/2018
	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 4650 GARRETT AVENUE APPLE VALLEY, MN 55124	<u> 10/</u>	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	Nursing (IDON) sta to complete rehabil residents and if una	ted she expected nursing staff itation programs with the able to complete the task staff otify the nurse and nurse	F€	388			
	R114 stated she did and although she h occupational therap range-of-motion fro every evening at be depended on which	on 10/15/18 at 5:07 p.m., d not have use of her right arm ad physical therapy (PT) and by (OT) she had not received m the nursing assistants edtime. R114 explained it a staff was scheduled on the Il staff were knowledgeable on					
	diagnoses including multiple sclerosis (I restless leg syndro	printed 10/18/18, noted g: functional quadriplegia, MS, pain, muscle spasm, me related to MS, hemiplegia, thritis and muscle weakness.					
	verified R114 did no adverse behaviors, mental status noted intact. The Care As 1/15/18, did not inc	Set (MDS) dated 1/15/18, of have dementia and had no memory loss or changes in d, and R114's cognition was sessment Area (CAA) dated lude any information restorative nursing (PROM).					
	Group 6 of 8 , dated	re and Health Rehab Sheet, d 10/1/18, directed staff to DM daily for R114. The					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY PLETED
		245264	B. WING			1	C 18/2018
	PROVIDER OR SUPPLIER	VALLEY		1	TREET ADDRESS, CITY, STATE, ZIP CODE 4650 GARRETT AVENUE APPLE VALLEY, MN 55124	1 10/	10/2010
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 688	undated Resident Salso verified R114 v (PROM) daily at be R114's Care Plan, I 10/17/18, directed bedtime and include ankle dorsi flexion, and log roll. The Augustana Heavalley Point of Care through 10/18/18, services from staff period. The Physical Thera Progress Report and certification period noted PT would see RNP (Restorative N with staff with at leasy order to maximize the and spasming on a medication interver indicated R114 was about 50% of their Occupational Receupdated Treatment 10/1/18 through 10, and Caregiver Trair on ROM to be done any further contract extremities. The recompliant and partistrengthening exerces	Sheet (NA assignment sheet) vas to receive passive ROM	F6	888			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		245264	B. WING		10	C / 18/2018
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CO 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 688	On 10/17/18 at 1:3 clarified R114 was week and in additionally to all extremition on 2017 at 2:10 purcare plan included directives and addenursing assistants of is in the current care sheets. She also strain the current care sheets. The also strain the current of the compact of the compa	1 p.m. the director of therapy seen by therapy twice each on received general PROM es on the evening shift. m., RN-B verified the current daily restorative nursing ed she absolutely expected the complete PROM for R114 as it are plan and their assignment ated that the care plan ed directions in R114's room for RN-B proceeded to R114's and documentation /direction or an PROM or exercise for R114. You on 10/18/18, at 1:10 p.m., the sursing (IDON) stated she complete all cares and services care plan. She further stated if ming ROM for R114, she to report why it was not DN concluded, "The facilityings regarding restorative y is making notes. We are	F6	88		
F 689 SS=D	assistance. Free of Accident Ha CFR(s): 483.25(d)(azards/Supervision/Devices 1)(2)	F6	89		11/29/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245264	B. WING_		1	C 18/2018
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124	, , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPRO	ULD BE	(X5) COMPLETION DATE
F 689	as free of accident §483.25(d)(2)Each supervision and as accidents. This REQUIREMEN by: Based on observat review, the facility f comprehensive ass and evaluation for s for 1 of 1 resident (Findings include: R455's resident fac indicated R455 was 9/29/18, and diagno nicotine dependent weakness. During an initial ent 10/15/18, the admir current smokers res During observation 2:09 p.m. R455 was pack of cigarettes a table in his room. R and independently wheelchair, to the s smoke free. R455 i	ats. Issure that - resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent INT is not met as evidenced sion, interview and document ailed to ensure a ressment, ongoing monitoring safe smoking was completed R455) reviewed for smoking. The sheet printed on 10/17/18, and admitted to the facility on reses included back pain, the and generalized muscle Trance conference interview on mistrator stated there were no	F 68	Immediate Plan of Correction: R455 was transferred to the hor 10/15/18 and remained there th duration of the survey. He retur the hospital on 10/24/18 and a risk assessment was completed time. He has since been dischathome. Identification of Other Residents in building who smoke at this time Measures Put in Place: Licensed nursing staff will be refore the importance of completing smoking risk assessment on an who is smoking, even if they are campus to smoke. Monitoring Mechanisms: Admissions staff will alert the administrator any time a resider smokes or has recently smoked pre-admission screening. The administrator will prompt nursin complete a smoking risk assess	rough the rned from smoking d at that arged to s: the -educated g a by resident e going off ont who d per the g staff to	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245264	B. WING			1	C 18/2018
	PROVIDER OR SUPPLIER TANA HCC OF APPLE	VALLEY		14	TREET ADDRESS, CITY, STATE, ZIP CODE 4650 GARRETT AVENUE PPLE VALLEY, MN 55124	1 10/	10/2010
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	On 10/15/18, at 3:2 outside on the facili gazebo, in the midd smoking a cigarette burns on his fingers extinguished his cigaretic burns on his fingers extinguished his cigaretic facility would lock that assessment was considered in the fact of th	ity property, inside the alle of the facility driveway in R455 did not have any is and/or clothing and garette onto the ground. 10/15/18, at 2:33 p.m. 10/15/18, at 2:33 p.m. 10/15/18, at 2:35 p.m. 10/15/18, identified and attention of R455's indicated R455's indicated R455's indicated R455's indicated R455's indicated R455's indicated related to R455's indicated related to R455's indicated R455's indicated R455's indicated R455's indicated R455's indicated related to R455's indicated R	F 6	889	the resident is smoking. Person responsible for compliance Administrator is responsible for compliance.	::	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245264	B. WING			1	C 18/2018
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HCC OF APPLE VALLEY				14	TREET ADDRESS, CITY, STATE, ZIP CODE 4650 GARRETT AVENUE PPLE VALLEY, MN 55124	101	10/2010
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	10/15/18, at 4:00 p. smoking assessme During an interview RN-F verified there believed to smoke identified the reside the facility electronic R455 did not have a completed. During a follow-up if 12:45 p.m. RN-F considered to smoke. During interview on director of nursing (expectation that a scompleted for any replanned. The DON would need to have with the ability to le Furthermore, the Designation. The facility policy Section 10/2017, indicated will be offered smol prior to being allow campus, resident with a Augustana Cliento determine if this observation will be quarterly, with signing PRN (as needed). If the policy is smoked to determine if this observation will be quarterly, with signing PRN (as needed). If the policy is more than the policy is the policy of the policy is the policy of the policy is the policy of the policy	m. and lacked evidence of a nt. on 10/15/18, at 3:44 p.m. was a resident who she residing on the unit. RN-F ent to be R455. RN-F reviewed c medical record and revealed a smoking risk observation onterview on 10/17/18, at onfirmed R455 did smoke, fied R455 "goes off of the	F6	89			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245264	B. WING	_		l	C 18/2018
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HCC OF APPLE VALLEY				14	TREET ADDRESS, CITY, STATE, ZIP CODE 4650 GARRETT AVENUE APPLE VALLEY, MN 55124	<u> 10/</u>	10/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689 F 690 SS=D	Continued From page 23 care plan." Bowel/Bladder Incontinence, Catheter, UTI			\$89 \$90	DEFICIENCY)		11/29/18
	receives appropriate prevent urinary trace continence to the essential systems of the essential	a resident with fecal					
		e treatment and services to ormal bowel function as					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		СОМ	(X3) DATE SURVEY COMPLETED	
		245264	B. WING		l	C 19/2019	
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HCC OF APPLE VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 690	by: Based on observatoreview, the facility frassess toileting need interventions were (R453) reviewed for needed intermittent bladder from urine. Findings include: During initial intervit R453 stated that shad since her surgery in (a tube used to drait R453 further stated to "empty her bladding (10/13/18) arout (unable to identify) complete the cather further identified that the catheterization output was almost and Furthermore, R453 spoken with the product of the product of the catheterization output was almost and (PVR) the amount of the cusing the restroom) hours instead of even sure she would hour often. R453's Resident Faindicated R453 admits a special product of the control of the cusing the restroom) hours instead of even sure she would hour often.	ion, interview and document ailed to comprehensively eds to ensure appropriate provided for 1 of 5 residents in bladder continence, and who catheterization to drain ew on 10/15/18, at 1:23 p.m. are required to be catheterized in order to empty her bladder in urine from the bladder). That she had asked the nurse are she felt full" two nights and 5:00 a.m. but the nurse indicated she was unable to terization at that time. R453 at it had taken two hours until was completed and her urine 1000 milliliters (ml). Verbalized that she had ovider earlier in the asked for post void residual (of urine left in the bladder after to be checked every six ery six hours as needed to have her bladder checked are Sheet printed on 10/18/18, nitted to the facility on noses included cervical disc	F 69	Immediate plan of correction orders regarding straight cawere updated on 10/18/18. Identification of other reside was completed of other resistraight catheter orders to end of those orders. Measures put in place: Lichave been re-educated on related to properly assessing urinary retention and bladd management. Monitoring mechanisms: Find catheter orders will be audited and then monthly X 2 month proper orders are in place as followed. Results of audits reviewed by the facility's Quand further monitoring will be recommended by them as in the summer of the	ents: An audit sidents with ensure clarity ensed staff the policy ng residents for er Residents with ited weekly X 4 hs to ensure and being will be API committee be		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BU I LD	TIPLE CONSTR ING	UCTION	COM	E SURVEY IPLETED
		245264	B. WING				C 1 18/2018
	PROVIDER OR SUPPLIER	VALLEY		14650 GARI	DRESS, CITY, STATE, ZIP CODE RETT AVENUE ALLEY, MN 55124	,	10,2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EA	PROVIDER'S PLAN OF CORREC ACH CORRECTIVE ACTION SHO ISS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 690	R453's physician arindicated "Patient in catheterization eve However, the physician arindicated "Patient may require the requency and 10/11/18, indicated "Patient may need catheterization eve R453's discharge dischar	dmission orders 10/11/18, may need straight intermittent ry six hours as needed." cian admission orders lacked a parameters. ers from the hospital dated under discharge instructions straight intermittent ry 6 hours" and included liagnoses to be cervical ression on the cervical spinal nic bladder (bladder was distended and needed to exed. RN-D indicated all PVRs corded in the nurse progress on 10/17/18, at 8:38 a.m. and not been able to urinate on 9/15/18. R453 indicated if she had been catheterized in	F6	90			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
		245264	B. WING _		1	C / 18/2018	
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 690	PVR and catheteriz urine in R453's blace PVR results would treatment administration on urse practitioner (aware during visit v R453 felt that she has catheterized. The Nacheduled R453's in the would have been be monitored every. The NP reviewed "on the made aware of R453's PVRs or catheterized. The Nacheduled R453's PVRs or catheterized aware of R453's care plan reached aware of R453's replan lacked excatheterized, PVRs address R453's diameterized, PVRs address R453's acatheterioutput; -On 10/14/18, at 9: R453 was catheterioutput; -On 10/14/18, at 12	se would need to check R453's to if there was over 350 ml of odder. RN-F indicated R453's be documented on the ration record (TAR). In 10/18/18, at 9:00 a.m. R453's NP) stated she was made with R453 on 10/15/18 that had waited too long to be NP indicated that she PVRs for every 6 hours and as indication. The NP confirmed expected for R453's PVRs to a shift and/ or every six hours. It call notes and stated she was any delay in completion of the terizations. Existed 10/16/18, indicated at of bladder and to provide the timent episodes and indicated and every two hours. R453's widence of R453's need to be a completed and did not agnosis of neurogenic bladder.	F 69				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '	PLE CONSTRUCTION (2)	X3) DATE SURVEY COMPLETED
		245264	B. WING _		C 10/18/2018
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124	10/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
	-On 10/14/18, at 5:: R453 was catheter output; -On 10/14/18, at 11 R453 was catheter output; -On 10/15/18, at 9:: catheterized and had on 10/16/18, at 2:3 notes and TAR lack ongoing assessme. During interview or interim director of inher expectation for bladder status at lesscheduled eight house on 10/18/18, at 10: assessment was resulted. The facility policy of catheterization is pretention. Dialysis CFR(s): 483.25(I) §483.25(I) Dialysis.	30 p.m. the note indicated ized and had 625 ml of urine :32 p.m. the TAR indicated ized and had 600 ml of urine 30 a.m. indicated R453 was ad 550 ml of urine output. A p.m. R453's nurse progress and evidence of every six hour not of R453's bladder status. In 10/18/18, at 10:44 a.m. the trursing (IDON) stated it was the nurse to assess R453's ast one time during their ur shift. 35 a.m. R453's bladder equested and not provided. Catheter: Straight/ Indwelling 7, indicated "straight erformed torelieve urinary	F 69		11/29/18
	require dialysis rec with professional st comprehensive per the residents' goals This REQUIREMEI by: Based on observa	eive such services, consistent candards of practice, the son-centered care plan, and		Immediate Plan of Correction: R134 orders related to dialysis dress	sing

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
			7 . BOILD			(
		245264	B. WING			10/	18/2018
	PROVIDER OR SUPPLIER ANA HCC OF APPLE	VALLEY		14	TREET ADDRESS, CITY, STATE, ZIP CODE 4650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 698	access site was assiplan of was develop reviewed for dialysis. Findings include: R134's admission Mated 10/5/18, identificated, required extedaily living (ADL's), dialysis. R134's facindicated R134 had dependence on rendisease and identificated facility on 9/28/18. R134's Care Area A 10/5/18, identified Fhowever, lacked do hemodialysis central intravenous access directly into the head and required monitibleeding, ensure drarea remained dry) On 10/16/18, at 8:5 and interviewed. Redialysis three times in a neighboring too in her right upper clashe had to stop the her dressing coveridown the collar of her transparent dressing R134's chest wall we from the port that we reviewed that we find the port that we find the single port of the port that we find the port	Minimum Data Set (MDS) tified R134 was cognitively ensive assist with activities of and identified R134 received the sheet printed on 10/18/18, I active diagnoses of tal dialysis, end stage renal tied R134 admitted to the Assessment (CAA) dated R134 received dialysis tocumentation of R134's tal venous catheter ([CVC] to for dialysis which goes art and is at risk for infection) toring of the CVC (drainage, tressing remained intact and	F	398	and checking of bruit were corrected 10/17/18. Identification of Other Residents: All other residents on dialysis were reviewed to ensure orders were actin reflecting the correct type of dialgaccess and care of that access. Measures Put in Place: Licensed staff was educated regard different types of dialysis access at care of those access points. Licenstaff were re-educated on the dialy care policy. Monitoring Mechanisms: A random sample of residents on owill be audited weekly X 4 weeks at then monthly X 2 months to ensure orders and care plan match the typicare the resident needs related to dialysis. Results of the audits will reviewed by the facility □s QAPI committee and further monitoring werecommended by them as indicate. Person responsible for compliance Director of nursing is responsible for compliance.	ding nd the sed sis	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245264	B. WING _		I	C / 18/2018
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		10,2010
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F 698	over the CVC was dialysis clinic. R134 many times the nur recall there was a formal the was a formal there was a formal the was a formal there was	only to be changed at the a was unable to recall how sees had attempted but did ew times since admission. If p.m. R134's care plan was plan dated 10/1/18, revealed ysis and indicated R134 had a cort. The care plan directed k dialysis shunt for bruit (a sify artery patency) every shift essing from the dialysis fistula is site for dialysis) site "on the reform dialysis." Onlysician orders dated check shunt for bruit every is site for signs and symptoms if location notify medical doctor remove dressing from dialysis er they return from dialysis." Treatment administration record ed on 10/16/18, at 3:02 p.m. staff to "check shunt for bruit access site for signs and ion. Record location, notify indicated," and "remove is site on the shift after they indicated," and "remove is site on the shift after they indicated, at 8:33 a.m. iurse (LPN)-B verified R134's as to be completed on	F 69	8		

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	PROVIDER OR SUPPLIER	VALLEY		1	STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124	1 10/	10/2010
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 698	During phone interview of R134's dialysis verified R134 had a clinic manager furth covering the CVC vintact and dressing the dialysis clinic state verified R134 did not be removed to be removed before dialysis days and a every shift. RN-I veheard with a CVC facility electronic midialysis care protocolautomatically popul stated these were sneed to be personal assessment. Further have a CVC and infacility staff not chart the dialysis clinic with a covery of the dialysis clinic with a covery shift. RN-I veheard with a CVC facility electronic midialysis care protocolautomatically popul stated these were sneed to be personal assessment. Further have a CVC and infacility staff not chart the dialysis clinic with a covery of nursing (expectation for an account of the covery of the co	view on 10/17/18, at 9:41 a.m. is clinic, the clinic manager a right upper chest CVC. The ner stated that all dressings were to remain clean, dry and is were only to be changed by aff. The clinic manager further of have a dialysis fistula. 10/17/18, at 12:37 p.m. dialysis access port was on ever, verified the dialysis it found within the CAAs. alysis access site location and thered from the physician it progress notes. 10/17/18, at 2:24 p.m. RN-I, alysis care plan and physician wledged R134's dressing was are bed after dialysis on bruit was to be assessed rified a bruit would not be RN-I revealed that within the edical record, there were not orders that had been atted for R134. RN-I further standard orders and would dized following each resident termore, RN-I verified R134 did dicated it was her expectation nige the dressing and to notify	F	698			

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	would need to obta access site care fol assessment. During interview on stated she was una assessment. A facility policy title identified "1. Residireceive comprehe of care. 2. Facility vassessment of the Nurse Aide Peform CFR(s): 483.35(d)(f) Reguments (green) (g	N further stated the nurse in accurate orders for dialysis allowing the completed in 10/18/18, at 12:29 p.m. RN-Fable to locate a dialysis and Dialysis dated 6/28/18, ents who require dialysis will ensive person-centered plan will provide ongoing resident's condition" Review-12 hr/yr In-Service 7) Ular in-service education. In the englete a performance review at least once every 12 provide regular in-service in the outcome of these attraining must comply with the 83.95(g). NT is not met as evidenced and document review, the englete annual performance of 4 of 5 nursing assistants of NA-E) who had worked at a year.	F 6		Immediate Plan of Correction: Performance evaluations for NA-B, NA-D, NA-E were completed by 11. Identification of Other Residents: Human resource director complete audit of NAR staff to determine if ar other performance evaluations are overdue. Measures Put in Place:	/29/18. d an	11/29/18
	NA-B's date of hire	(DOH) with the facility was			The 1st of each month the HR Dire	ctor	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10/1	10/2010
AUCUST	ANA HCC OF ADDI E	VALLEY	/	14650 GARRETT AVENUE		
AUGUST	ANA HCC OF APPLE	VALLET	/	APPLE VALLEY, MN 55124		
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F 730	Continued From pa	ge 32	F 730			
	9/12/11, and last PI 9/8/17.	completed by the facility was		will send a list the employees due feed evaluation that month. The list will		
	last PE completed			given to each of the nurse manage HR Director does not receive comp evaluation by the 25th she will notif nurse manager, Director of Nursing	oleted fy the g and	
	NA-D's DOH with the last PE completed v	ne facility was 10/2/89, and was 8/7/15.		Administrator to assure completion end of the month.	by	
	NA-E's DOH with the PE completed was	ne facility was 5/8/15, and last 9/8/17.		Monitoring Mechanisms: An audit of 10 NARs per month will completed X 3 months to ensure the		
	Nursing (IDON) ver NA-E's last PE date nurse managers co expected them to b year after the last F or after". IDON con NA-E's PEs were n	9 p.m. Interim Director of ified NA-B, NA-C, NA-D and completed. IDON stated the impleted the PEs and she e completed "yearly", one PE completed "30 days before firmed NA-B, NA-C, NA-D and ot current, and had not been DON also confirmed Human		performance evaluations have bee completed on time. Results of tho audits will be reviewed by the facilit QAPI committee and further monitor will be recommended by them as indicated. Person responsible for compliance Director of Human Resources is	n ose ty⊡s oring	
	Resources had no NA-B, NA-C, NA-D	other PEs completed for and NA-E.		responsible for compliance.		
	11/15, indicated "		F 732			11/29/18
	must post the follow basis: (i) Facility name. (ii) The current date (iii) The total number	requirements. The facility ving information on a daily				

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		245264	B. WING		C 10/18/2018
	PROVIDER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124	1 10/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION
F 732	for resident care per (A) Registered nurse (B) Licensed practivocational nurses (C) Certified nurse (iv) Resident censury (E) The facility must specified in paragradily basis at the beroid (E) In a prominent presidents and visited (E) Residents (E) Resid	sing staff directly responsible or shift: ses. cal nurses or licensed as defined under State law). aides. is. ing requirements. post the nurse staffing data aph (g)(1) of this section on a aginning of each shift. bated as follows: able format. blace readily accessible to ors. ic access to posted nurse facility must, upon oral or ke nurse staffing data olic for review at a cost not to nity standard. ity data retention facility must maintain the staffing data for a minimum of equired by State law,	F 732	Immediate Plan of Correction: Staffing coordinators updated thei process to include updating the ce and staffing hours per policy. Identification of Other Residents: other residents implace: Education	ensus No

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG	COM	E SURVEY IPLETED
		245264	B. WING _		l l	C 18/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		10/2010
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F 732	Findings include: On 10/17/18, at 8:5 10/16/18, was obset board on the 1st flood on the 1st flood on 10/18/18, at 8:4 10/17/18, was obset (RN)-J. RN-J verificated the log need daily and was postet the RN charge nurse not work. RN-J state throughout the day the book was updanever been instruct census or staffing changed day. On 10/18/18, at 9:0 hanging the DNHL RN-A stated the log and the log was no on the Master sheet on 10/18/18, at 9:3 Nursing (IDON) state posted daily, updat day, and should be pick ups, staffing an also stated when cobe adjusted. IDON should be an accurrand census was in On 10/18/18, at 12:	50 a.m. the DNHL dated erved posted on the bulletin for across from the elevators. 57 a.m. the DNHL dated erved with Registered Nurse ed the log dated 10/17/18, and ed to be hung by 9:00 a.m. ed by the schedulers and/or by se when the schedulers did ed the DNHL was not updated, and only the master sheet in ted. RN-J stated she had ed to update the log with changes. RN-J stated census es did occur throughout the ed to updated during the day, only et in the book was. 51 a.m. Interim Director of ted the DNHL needed to be ed routinely throughout the updated with any call ins, and census changed staffing would stated, "the posting [DNHL] ate picture of what staffing	F 73	completed with facility staffing coordinators on the policy for staffing and census information posted staffing hours. Monitoring Mechanisms: A rasample of dates will be audited 3 months to ensure that the postaffing hours have been post updated properly. Results of will be reviewed by the facility committee and further monitor recommended by them. Person responsible for complication of nursing is responsite compliance.	updating on on the andom d monthly X osted ed and these audits a QAPI ring will be	

STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI			LETED
		245264	B. WING_		C 10/1	; 8/2018
	DER OR SUPPLIER	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		0/2010
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chai sche RN did i log v putti the state at the state at the state at the state chair the stat	edulers worked charge posted not work. Schewith changes in ing up a 2nd log changes had been followed as facility. iew of 10/17/18 cated no update nges. facility policy Facility 100 posted by 81 posted by 82 posted by 83 posted during the he staffing officients [DNHL] for a policy policy policy facility fa	ng staff. Scheduler stated seven days a week and the the DNHL when schedulers duler stated she updated the hours nursing staff worked by g, but did not keep the 1st log een updated from. Scheduler this procedure since starting this procedure since starting and 10/18/18, DNHL ed census and nursing staff costing of Staffing Hours datedNumbers of direct care staff and a.m. daily" and changes to ation due to call-ins or major ould be made for each shift as day. The policy also indicated, we will keep a file of staffing a minimum of 18 months." for Dementia 3) sident who displays or is mentia, receives the ent and services to attain or highest practicable physical, osocial well-being. NT is not met as evidenced tion, interview and document failed to ensure ongoing I behaviors were ssessed, failed to ensure	F 7		9/18/18 . A on	11/29/18

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
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		245264	B. WING) 8/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	10/	10/2010
					4650 GARRETT AVENUE		
AUGUST	ANA HCC OF APPLE	VALLEY		Α	APPLE VALLEY, MN 55124		
(X4) I D	SUMMARY STA	TEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION	ı	(X5)
PREF I X TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLÉTION DATE
					DEFICIENCY)		
F 744	Continued From no	vao 36		7 4 4			
1 / 44		•	Γ,	744	Olivia of Decelor (AOD) Oc. 44		
		ed to determine whether			Clinic of Psychology (ACP). On 11/		
		al help was necessary for 1 of			Family has agreed to ACP referral	and	
		reviewed for dementia care,			that referral has been made. R129		
		increased physical and verbal			behavior care plan will be reviewed	by the	
		distress to themselves and			IDT and updated 11/15/18.		
		the facility failed to update the					
		actitioner of increased			Identification of Other Residents:		
		ed to ensure medication used			audit was completed of all other re		
		vas administered as ordered.			with a diagnosis of dementia to en		
	Findings include:				their care plan includes individualiz	ed	
		imum data set (MDS)			interventions.		
		7/11/18, included a diagnosis					
		uarterly MDS indicated R129			Measures Put in Place: Behavior r	_	
		nterviewed because R129			will be held with Interdisciplinary te	am	
	_	nderstood. R129 was		Mon-Friday (with the exception of			
		g both long and short term			holidays) to allow designated time		
		d inattentive behaviors			to review any noted changes in res		
		ocusing attention, being easily			behaviors. IDT will review potentia		
		ficulty keeping track of what			triggers to the change in behavior		
		havioral symptoms included			do a comprehensive review of resi		
	both physical and v	verbal behaviors occurring 1-3			experiencing changes in behavior.	The	
		ook back period. The MDS			team will develop a plan including		
		9 was hard of hearing, and			assuring medications are being		
	required supervisio	n with some activities of daily			administered as ordered, notification	n to	
		pendent with walking using a			provider of changes, and referrals		
	walker and bed mo	bility.			to outside provider such as ACP as		
	R129's current care	e plan included a potential			indicated. Interdisciplinary team	vas	
		or originally identified 8/15/14,			educated on change to our current		
		oses of dementia, anxiety and			meeting structure to include review		
		ng. The care plan included			behavioral changes. Education is	being	
		on initiated 9/21/18, indicating			provided to licensed staff on the		
		proach R129 as needed when			importance of notifying the provide	•	
		reased. Other interventions			changes in behavior and the need	to	
	included offer time	for R129 to calm down before			comprehensively assess residents	that	
	re-approaching. R1	29's care plan also indicated			are experiencing changes in behave	ior in	
	a problem with alte	ration in cognition, identifying			order to determine the root cause of	of the	
	R129 as severely in	mpaired. R129's undated			change. Nursing staff will receive		
		are Sheet identified			education on Nov 14, 16th or 19th	related	

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F 744	behavioral interven nursing of behavior re-approach, and k safety checks at nig During an observed look, shaking and v over his wife who w to him. He stated, "call light was on, bu present in the hall. R129's distress and attended to R129. During an observat p.m. R129 and his out to the dining roomember (FM)- E with demonstrated no arinterview with FM-E she believes the far parents were no lor home. FM-E stated risk/benefit sheet, e behaviors if her par was aware of the ir medication error ar floor where her fath stated she and her facility multiple nigh believed much of R approach. Physician progress identified R129 as leasily redirectable, self and wife. The p Depakene strength	tions including notifying is toward spouse, eep room orderly, 30 minute ght and report refusal of cares. ion on 10/15/18, at 6:28 p.m. ion in his room with a distressed waving his hands, standing was sitting in a wheelchair next her pants are too tight." The ut no staff were observed. The surveyor alerted staff to ion on 10/16/2018, at 2:32 wife were observed heading om to play BINGO. Family as present and R129 gitated behaviors. During an eat 3:50 p.m., FM-E stated cility would be happy if her inger residents of the nursing she had received a explaining the risks of R129's rents stay at the facility. FM-E increased behavior, the ind had pictures of blood on the iner had fallen. FM-E also brother had stayed over at the interest in the past, and stated she into in the past, and stated she into in 7/3/18, the physician having behaviors that were not resulting in some distress to olan was to increase from 250 mg (milligrams) at in the morning and 250 mg at	F	744	to properly approaching residents dementia and reporting changes in behavior to the nurse. Monitoring Mechanisms: Observate audits will be completed weekly by designated management staff. The observe staff interactions with residuith dementia. These audits will kneekly X 1 month and then monthly months. Results of the audits will reviewed by the facility QAPI committee and further monitoring was recommended by them as indicated. Person responsible for compliance Director of nursing is responsible for compliance.	tion ey will dents be done y X 2 be vill be d.	

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F 744	R129 had an order used to treat challe (milligrams) at bedt received from the president's Depaken each morning, in at The order specified was to be updated behaviors in 2 weel inadvertently stopp. Following the discotthe nursing progres 9/15/18, revealed a including refusing ormedications; combipunching and biting staff; pounding his room; pounding on charge at staff; refulegs; not letting staff police; trying to get to get wife into bed and standing lift for angry; grabbing stawould not let go; aginjury to head. Ever were documented, facility interdisciplin reassessed R129's needs, re-assessed interventions, deveindividualized non-pand/or sought outsi psychologist and/or R129's dementia rebehavioral needs. The Nurse Practitions	for Depakene (a medication nging behaviors) 250 mg ime. On 7/3/18, an order was physician to increase the eto include a 125 mg dose addition to the bedtime dose. If the nurse practitioner (NP) on R129's distress and ks. The facility had ed the Depakene on 7/17/18. Intinuation of the Depakene, as notes from 7/24/18 through an increase in behaviors eares, baths and taking active towards staff; hitting, g staff; swearing and yelling at wheelchair on the floor in his the wall; swing walker at staff; asing dressing change to his eff help wife, wanting to call the wife out of her chairs, trying, while she needed two person transfers; pacing in room; aff ans spouse by arms and gitation that led to fall with the though these behaviors there was no evidence the lary team comprehensively individualized dementia care	F	744			

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F 744	include Depakene. NP indicated a diagonal behavioral and psydementia (BPSD) thearing impairment continue mood state Progress note date indicated a family in R129's continued by R129 behaviors care appropriate medicate frustration with staff anticipation of needs the night as they are this in the past. Farmoving the couple believe it create mois not open to sepathe dose to get his control. There was non-pharmacologic the interdisciplinary to have R129 be exprofessional service psychiatrist. The medication error discovered on 9/20 (RN)-C while investigation portion of acknowledged an insince the time of discovered on 9/15/18. NA-him because he was	Under assessment and plan gnosis of dementia with chological symptoms of that "staff approach in light of matters. Certainly, also bilizer." d 9/19/18, at 2:27 p.m., neeting was held to discuss ehaviors. Family believes in be managed with tion. Family talked about approach and the lack of its. Family is not open to stay the still recovering from doing mily is not open to transfer to to a new facility as they are risk for the couple. Family rating the couple as they y lead to more behaviors. NP kote and will slowly increase mood and behaviors under no evidence of additional al interventions developed by a (IDT) team, or request made a such as a psychologist or the couple was a psychologist or the couple was a psychologist or the couple and the period of the medication error report the crease in R129's behaviors	F 7	44		

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		245264	B. WING	i	10	C / 18/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		710/2010
(X4) I D PREF I X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPR I ATE	(X5) COMPLETION DATE
F 744	noise and turned and R129 was agitated his wife and R129 were helping her end NA-H acknowledge increased over the protective behavior. During interview of RN-C verified that Depakene for 63 dincorrectly entered record. RN-C states Depakene again of Efforts to interview with the interim direct acknowledged she aware of the medical recognized sooner have been updated behaviors. A facility policy "Definitional and psychological and psychologic	and R129 was on the floor. If because he was trying to help did not understand that they even when we tried to explain, and that R129's agitation had a summer and mostly involved rs related to R129's wife. In 10/17/2018, at 2:02 p.m. R129 had not received his lays due to the order being and into the electronic medical and R129 had his first dose of an 9/19/18 at 8:00 a.m In the NP were unsuccessful. In the NP were unsuccessful, where the contract of nursing (IDON), she are had only recently became cation error as she was not ity during the occurrence. She attorned the physician should a regarding R129's increase in the mentia Care," last revised a resident who displays or is mentia, receives the ent and services to attain or highest practicable physical,	F 7	744		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION ING	COM	re survey Mpleted
		245264	B. WING		1	C / 18/2018
	PROVIDER OR SUPPLIER	VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 755 SS=D	CFR(s): 483.45(a)(§483.45 Pharmacy The facility must prodrugs and biological them under an agre §483.70(g). The fa personnel to admin permits, but only ur a licensed nurse. §483.45(a) Procedi pharmaceutical ser that assure the acc dispensing, and ad biologicals) to meet §483.45(b) Service must employ or obt pharmacist who- §483.45(b)(1) Prov aspects of the prov the facility. §483.45(b)(2) Estal receipt and disposit sufficient detail to e reconciliation; and §483.45(b)(3) Dete in order and that ar drugs is maintained This REQUIREMEN	Services ovide routine and emergency als to its residents, or obtain eement described in cility may permit unlicensed ister drugs if State law nder the general supervision of ures. A facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and t the needs of each resident. Consultation. The facility cain the services of a licensed ides consultation on all ision of pharmacy services in blishes a system of records of tion of all controlled drugs in	F 7	Immediate Plan of Correction	: Order for	11/29/18
		ure medications were		polyvinyl eye drops for R448 v		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245264	B. WING			10/1	 18/2018
	PROVIDER OR SUPPLIER TANA HCC OF APPLE	VALLEY		14	TREET ADDRESS, CITY, STATE, ZIP CODE 4650 GARRETT AVENUE PPLE VALLEY, MN 55124	,	
(X4) I D PREF I X TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 755	available and admi physician for 1 of 1 complaints of eye of unavailable. Findings include: R448's face sheet R448 was admitted face sheet identifie eye syndrome of unavailable. During an initial integrate personal eye dro further stated she of indicated her eyes having the eye dro further stated she had a received her eye dro further stated she had a received her eye dro fundicated she had a received	nistered as prescribed by the resident (R448) with drop medication being printed on 10/17/18, indicated to the facility on 10/1/18. The d R448 had a diagnosis of dry aspecified lacrimal gland. Berview on 10/15/18, at 1:10 he had not gotten her ps since admission. R488 did not produce tears and had gotten blurry from not ps. Furthermore, R448 asked a nurse why she hadn't rops and was told the eye k order with the pharmacy. By p.m. R448's physician red and included polycinyl ening agent) one drop to be the eyes, three times daily for a e syndrome of lacrimal gland. included Refresh classic (eye two drops to both eyes, four ded for dry eye syndrome of las's allergies included enadryl, bupropion, on, ibuprofen, penicillin,	F 7	755	discontinued on 10/17/18. Reside since discharged to home. Identification of Other Residents: audit was completed of all medicate being documented as not given du available. Follow up has been conwith pharmacy and/or provider as indicated for those medications. Measures Put in Place: Licensed staff and TMAs have been re-educated on the medication administration policy and the imposof reaching out to pharmacy and in the provider if a medication is not available, so a substitute medication be ordered if indicated. Monitoring Mechanisms: An audit will be completed weekly weeks and then monthly X 1 for medications being documented as given due to not available. Results these audits will be reviewed by the facility S QAPI committee and further monitoring will be completed per the recommendations as indicated. Person responsible for compliance Director of nursing is responsible for compliance.	An tions le to not mpleted en rtance otifying on can X 8 not s of le ther neir	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BU I LD		CONSTRUCTION	COM	E SURVEY PLETED
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	PROVIDER OR SUPPLIER	VALLEY		146	REET ADDRESS, CITY, STATE, ZIP CODE 650 GARRETT AVENUE PLE VALLEY, MN 55124	,	10/2010
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F 755	were "Drug/ Item uperiod of 10/4/18 at (10/15/18) which in p.m. and 6:00 p.m. MAR further identific classic drops had not be classic drops had not be changed practical numbers of the was unaware of drops were not at the would need to contain p.m. LPN-C reveals indicated the polyviback order and the be changed. LPN-C mail for the provide substitute eye drop call. R448's nurse program ask dr [doctor]. If the eye drop;" the note provider was updat and the provider was updat and	navailable" during the time at 6:00 p.m. to current cluded an 8:00 a.m., 12:00 administration times. R448's led the "as needed" Refresh not been administered. 10/16/18, at 1:29 p.m. urse (LPN)-C indicated that of why R448's polyvinyl alcohol ne facility and stated she act the pharmacy. At 1:35 led the facility pharmacy nyl alcohol drops were on order for eye drops needed to c indicated she left a voice r to obtain an order for a and was awaiting a return less notes were reviewed: 1/4/18, at 11:29 p.m. indicated cy, eye drop not available. To ey want to change to different lacked evidence that R448's	F 7	755			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER			140	REET ADDRESS, CITY, STATE, ZIP CODE 650 GARRETT AVENUE PPLE VALLEY, MN 55124	107	10/2010
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	practitioner] to check different medication refresh that helps who PM nurse to f/u who PM-D stated she hadrops from the as nurse the pharmacy to see who were not at the facilindicated the provide polyvinyl eye drop of unavailable at the further indicated the R448's polyvinyl eye drops scheduled the During a telephone a.m. the facility phat that if the pharmacy available, the pharmacy available, the pharmacy consultant then be expected to wait for the medical pharmacy consultant information was relimedication was unafacility to follow-up at the pharmacy consultant information was unafacility to follow-up at the pharmacy to follow at the pharmacy to follow at the pharmacy to follow at the pharmacy to follow-up at the pharmacy to follow	ck if we can change it to a in. Pt also had prn (as needed) with her dry eyes. Will pass on with NP." 10/17/18, at 11:34 a.m. and given R448's Refresh eye needed list in the morning. It is she would need to call the hy the polyvinyl eye drops lity. At 12:27 p.m. LPN-D alter needed to change R448's proder as these were acility pharmacy. LPN-D are provider had changed e drop order to Refresh eye	F 7	555			
	During an interview the director of nursi	on 10/18/18, at 10:29 a.m. on (DON) stated that if the ion was unavailable by the					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION (` '	SURVEY PLETED
		245264	B. WING			10/1	 18/2018
	PROVIDER OR SUPPLIER	VALLEY		14	TREET ADDRESS, CITY, STATE, ZIP CODE 4650 GARRETT AVENUE PPLE VALLEY, MN 55124		10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 755	contact the provide alternative medicat	t was her expectation to r and obtain an order for an	F 7	'55			
F 760 SS=G	8/20/18, indicated "medications, conta- Residents are Free	c. If unable to obtain ct the resident's physician." of Significant Med Errors	F 7	'60			11/29/18
	medication errors. This REQUIREMED by: Based on observareview, the facility fresidents (R129) refree of significant magnetic personal pers	Issure that its- lents are free of any significant NT is not met as evidenced tion, interview, and document ailed to ensure 1 of 5 eviewed for dementia care was nedication error when order for tion used to treat seizures and ers) was not transcribed into cal record (EMR) according to ers. This resulted in actual ordidn't receive the medication ereased agitation, and fell tion requiring emergency care. Ition on 10/15/18, at 6:28 p.m. Indied in his room with a distressed taking and waving his hands, rife who was sitting in a him. He stated, "her pants are light was on, but no staff were in the hall. The surveyor 29's distress and an erson attended to R129. Inimum data set (MDS) 7/11/18, included a diagnosis			Immediate Plan of Correction: R129 Depakene was restarted on 9, upon discovery of medication error. discussion was held with daughter of 11/9/18 concerning on-going behaving and getting a referral to the Associated Clinic of Psychology. The daughter of discuss with brother and sister before agreeing to ACP. Augustana solution of National Procession was held regarding residuely behaviors and then discovery of medication error. Beginning 9/21 the discussed residents behaviors and of plan reviewed to ensure appropriate individualized interventions are in plant of the plant	A on iors ted will re day for and lents = IDT care e lace.	

F 760 Continued From page 46 of dementia. This quarterly MDS indicated R129 was unable to be interviewed because R129 was rarely/never understood. The MDS indicated R129 had long and short term memory deficits, exhibited inattentive behaviors including difficulty focusing attention, being easily distractible, and had difficulty keeping track of what was being said. According to the MDS, behavioral symptoms included both physical and verbal behaviors occurring during 1-3 days of the 7 day look back period. A review of R129's progress notes identified the following behavior documentation: Progress note dated 6/13/18, at 2:23 p.m.,	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			UI	<u>VIB NO.</u>	0938-0391
AUGUSTANA HCC OF APPLE VALLEY							COM	PLETED
AUGUSTANA HCC OF APPLE VALLEY (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 760 Continued From page 46 of dementia. This quarterly MDS indicated R129 was unable to be interviewed because R129 was unable to be interviewed because R129 was rarely/never understood. The MDS indicated R129 had long and short term memory deficits, exhibited inattentive behaviors including difficulty focusing attention, being easily distractible, and had difficulty keeping track of what was being said. According to the MDS, behavioral symptoms included both physical and verbal behaviors occurring during 1-3 days of the 7 day look back period. A review of R129's progress notes identified the following behavior documentation: Progress note dated 6/13/18, at 2:23 p.m.,			245264	B. WING			1	
AUGUSTANA HCC OF APPLE VALLEY (X4) ID PREFIX TAG (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 760 Continued From page 46 of dementia. This quarterly MDS indicated R129 was unable to be interviewed because R129 was rarely/never understood. The MDS indicated R129 had long and short term memory deficits, exhibited inattentive behaviors including difficulty focusing attention, being easily distractible, and had difficulty keeping track of what was being said. According to the MDS, behavioral symptoms included both physical and verbal behaviors occurring during 1-3 days of the 7 day look back period. A review of R129's progress notes identified the following behavior documentation: Progress note dated 6/13/18, at 2:23 p.m.,	NAME OF F	DOMED OF CHERTE		<u> </u>	C.	TREET ADDRESS CITY STATE 7ID CODE	101	10/2010
APPLE VALLEY, MN 55124 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 760 Continued From page 46 of dementia. This quarterly MDS indicated R129 was rarely/never understood. The MDS indicated R129 had long and short term memory deficits, exhibited inattentive behaviors including difficulty focusing attention, being easily distractible, and had difficulty keeping track of what was being said. According to the MDS, behavioral symptoms included both physical and verbal behaviors occurring during 1-3 days of the 7 day look back period. A review of R129's progress notes identified the following behavior documentation: Progress note dated 6/13/18, at 2:23 p.m.,	NAME OF F	-KOVIDER OR SUFFLIER						
APPLE VALLEY, MN 55124 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 760 Continued From page 46 of dementia. This quarterly MDS indicated R129 was rarely/never understood. The MDS indicated R129 was rarely/never understood. The MDS indicated R129 had long and short term memory deficits, exhibited inattentive behaviors including difficulty focusing attention, being easily distractible, and had difficulty keeping track of what was being said. According to the MDS, behavioral symptoms included both physical and verbal behaviors occurring during 1-3 days of the 7 day look back period. A review of R129's progress notes identified the following behavior documentation: Progress note dated 6/13/18, at 2:23 p.m.,	AUGUST	ANA HCC OF APPLE	VALLEY					
F 760 Continued From page 46 of dementia. This quarterly MDS indicated R129 was unable to be interviewed because R129 was rarely/never understood. The MDS indicated R129 had long and short term memory deficits, exhibited inattentive behaviors including difficulty focusing attention, being easily distractible, and had difficulty keeping track of what was being said. According to the MDS, behavioral symptoms included both physical and verbal behaviors occurring during 1-3 days of the 7 day look back period. A review of R129's progress notes identified the following behavior documentation: Progress note dated 6/13/18, at 2:23 p.m.,					Α	PPLE VALLEY, MN 55124		
of dementia. This quarterly MDS indicated R129 was unable to be interviewed because R129 was rarely/never understood. The MDS indicated R129 had long and short term memory deficits, exhibited inattentive behaviors including difficulty focusing attention, being easily distractible, and had difficulty keeping track of what was being said. According to the MDS, behavioral symptoms included both physical and verbal behaviors occurring during 1-3 days of the 7 day look back period. A review of R129's progress notes identified the following behavior documentation: Progress note dated 6/13/18, at 2:23 p.m.,	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
indicated R129 was agitated during the morning. R129 continued to state, "the police should be here!". After lunch R129 became frustrated waiting for his wife and he aggressively grabbed her purse 'nearly pulling her out of her seat.' - Progress note dated 6/21/18, at 11:02 a.m., indicated R129 appeared agitated and verbally aggressive with staff "What are you doing? Leave her alone! Just get the hell out of here!". R129 was banging on his nightstand and made a fist as if he was going to hit staff. - Physician progress note on 7/3/18, the physician identified R129 as having behaviors that were not easily redirectable, resulting in some distress to self and wife. The plan was to increase Depakene strength from 250 mg (milligrams) at bedtime to 125 mg in the morning and 250 mg at bedtime for mood stabilization. A Medication Error Report dated 9/20/18, identified the following medication error: R129 had an order for Depakene (a medication used to treat challenging behaviors) 250 mg (milligrams) at bedtime. On 7/3/18, an order was received from the physician to increase the resident's	F 760	of dementia. This quas unable to be in was rarely/never ur R129 had long and exhibited inattentive focusing attention, had difficulty keepir said. According to the symptoms included behaviors occurring look back period. A review of R129's following behavior of Progress note date indicated R129 was R129 continued to here!". After lunch waiting for his wife her purse 'nearly pure pure pure pure pure pure pure pure	uarterly MDS indicated R129 interviewed because R129 inderstood. The MDS indicated short term memory deficits, a behaviors including difficulty being easily distractible, and ing track of what was being the MDS, behavioral both physical and verbal during 1-3 days of the 7 day progress notes identified the documentation: ad 6/13/18, at 2:23 p.m., as agitated during the morning. State, "the police should be R129 became frustrated and he aggressively grabbed alling her out of her seat." the d6/21/18, at 11:02 a.m., becared agitated and verbally ff "What are you doing? List get the hell out of here!". On his nightstand and made a ing to hit staff. Is note on 7/3/18, the R129 as having behaviors or redirectable, resulting in left and wife. The plan was to be strength from 250 mg ime to 125 mg in the morning time for mood stabilization. Report dated 9/20/18, ing medication error: R129 epakene (a medication used to behaviors) 250 mg (milligrams) /18, an order was received	F 7	760	Measures Put in Place: Health information staff and license nurses have been re-educated on transcription of orders policy and the importance of verification of orders. Licensed staff have been re-educated the importance of notifying the prowith changes in behavioral symptom with changes in behavioral symptom Monitoring Mechanisms: A random sample of 10 charts perwill be reviewed for new orders and accuracy of those orders X 4 week then monthly X 2 months. Results audits will be reviewed by the facility QAPI committee and further monitor will be recommended by them as indicated. Person responsible for compliance Director of nursing is responsible for	the the ted on vider ms. week d s and s of the ty □s oring	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
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		245264	B. WING			10/	18/2018
	PROVIDER OR SUPPLIER ANA HCC OF APPLE	VALLEY		1	STREET ADDRESS, CITY, STATE, ZIP CODE 4650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) I D PREF I X TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	Depakene to include morning, in addition order specified the be updated on R12 2 weeks. However, indicate an end dat the 7/17/18 doses, discontinued. In act the NP or physiciar regarding the impainad on R129's behad on R129 purcausing medication staff approached walone she is fine." - Progress note datindicated R129 bedad indicated R129 bedad indicated R129 as a off his legs and refusesist. - Progress note datindicated R129 did of the night, trying the entering his side of - Progress note datindicated R129 did of the night, trying the entering his side of - Progress note data was holding wife, providing care, hitting swearing at staff. - Progress note data R129 or wife would breakfast, R129 co	le a 125 mg dose each note to the bedtime dose. The nurse practitioner (NP) was to 9's distress and behaviors in the order was transcribed to e in two weeks, and following the Depakene had been didition, there was no indication in had ever received an update of the additional Depakene	F	760			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BU I LD		ISTRUCTION		TE SURVEY MPLETED
		245264	B. WING			10	C 9/18/2018
	PROVIDER OR SUPPLIER	VALLEY	STREET ADDRESS, CITY, STATE, ZIP (14650 GARRETT AVENUE APPLE VALLEY, MN 55124		GARRETT AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 760	protective over wife stated R129 was p floor in his room Progress note da R129 difficult to rec wall and push assidoes not have pan spouse. R129 cont charge at staff Progress note da displayed 'major be wall, yelling, hitting when staff tried to late for breakfast. F. Progress note da refused dressing city - Progress note da did not want staff to wanting the police still up trying to hel - Progress note da on call light all night - Progress note da 129 refused bath Progress note da pressing call light roffered, bang on the door waiting for her chair Progress note da stated R129 trying 2 person/standing NAs approached to agitated, grabbed swould not let go. N R129 still angry, pages and the door waiting the go. N R129 still angry, pages and the door waiting the go. N R129 still angry, pages and the door waiting the go. N R129 still angry, pages and the door waiting the go. N R129 still angry, pages and the door waiting the go. N R129 still angry, pages and the door waiting the go. N R129 still angry, pages and the go. N R129 still angry, pages and the go.	e. Nursing assistant (NA) ounding his wheelchair on the ted 8/22/2018, at 6:21 a.m., direct, continues to pound on st light. R129 angry that wife ts on. Multiple attempts to help inues to swing walker at staff, ted 9/4/1,8 at 11:23 a.m., R129 ehaviors' today; pounding on several staff, aggressive assist wife. They were an hour Refused medications. ted 9/5/18 at 2:25 p.m., R129 hange to his legs. ted 9/7/18, at 1:44 a.m., 129 o help wife, kicking them out, called. Calmed down a little, p wife. ted 9/7/18, at 6:28 a.m., R129 at ted 9/8/18, at 5:27 p.m., R ted 9/10/18 2:18 p.m., R129 multiple times, even after assist the wall with his fist and stand in r help. Trying to get wife out of ted 9/11/18, 10:25 p.m., NA to get wife into bed. Wife is a lift assist for transfers. When a assist, R129 became spouse and staff by arms and A eventually got wife to bed. acing in room and pushing at. R129 believes family and	F 7	760			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		245264	B. WING			10/ ⁻	18/2018
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HCC OF APPLE VALLEY				14	TREET ADDRESS, CITY, STATE, ZIP CODE 4650 GARRETT AVENUE PPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	- The Nurse Practit dated 9/11/18, lister not include Depake plan NP indicated a behavioral and psydementia (BPSD) hearing impairment continue mood state. A progress note dindicated the NA ware R129. R129 became attempting to provide try to hit and push I weight pushed back hitting his head on bleeding on the back the emergency roof to close the wound. The medication errordiscovered on 9/20 (RN)-C while invested evaluation portion of dated 9/20/18, indicated 9/20/1	ioner (NP) progress note d R129's medications, but did the Under assessment and a diagnosis of dementia with chological symptoms of that "staff approach in light of matters. Certainly, also bilizer." ated 9/15/18 at 11:10 a.m., as present with wife and the combative when NA was decrete to wife. R129 began to NA and lost balance, body k and he went backwards, the floor. Contusion noted with the ck of the head. R129 sent to m and received three staples	F	760			

AND DIAM OF CORRECTION IN THE PROPERTY OF THE		A. BUILDING				E SURVEY PLETED	
		245264	B. WING	i			C 18/2018
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HCC OF APPLE VALLEY				STREET ADDRESS, CITY, STATE, ZIP CO 14650 GARRETT AVENUE APPLE VALLEY, MN 55124	DE		
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD B		(X5) COMPLETION DATE
F 761 SS=D	received his Depak order having been in EMR. RN-C stated medication error whand had reinstated R129 had his first of 9/19/18 at 8:00 a.m. although the transcretrospect she show the nurse received nurse who double of had not received furse who double of had not received furse with the interview buring an interview with the interim direct acknowledged she aware of the medical recognized sooner have been updated behaviors. The facility's 10/2020 policy indicated the will review order do transcription of ordet accurate. Label/Store Drugs at the state of the medical recognized sooner have been updated behaviors. The facility's 10/2020 policy indicated the will review order do transcription of ordet accurate. Label/Store Drugs at the state of	ene for 63 days due to the incorrectly entered into the the NP had identified the hile in the facility on 9/18/18, the medication. RN-C stated lose of Depakene again on in. RN-C further explained that ribing nurse stated in all have clarified the order, education. However, the checked the order transcription of the NP were unsuccessful. If on 10/18/2018, at 11:39 a.m., ector of nursing (IDON), she had only recently became ation error as she was not be during the occurrence. She tion error should have been and the physician should regarding R129's increase in 18, Transcription of Orders nurse that verifies the order cumentation and ensure a fullers has been signed and is		761			11/29/18
	Drugs and biological labeled in accordar professional princip appropriate access	g of Drugs and Biologicals als used in the facility must be not with currently accepted ales, and include the ory and cautionary e expiration date when					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION	СОМ	(X3) DATE SURVEY COMPLETED C	
	245264 B. WING				l l	18/2018	
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HCC OF APPLE VALLEY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				STREET ADDRESS, CITY, STATE, ZIP COI 14650 GARRETT AVENUE APPLE VALLEY, MN 55124	•		
(X4) I D PREF I X TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 761	§483.45(h)(1) In acc Federal laws, the fabiologicals in locked temperature contropersonnel to have a §483.45(h)(2) The separately locked, compartments for slisted in Schedule I Abuse Prevention a other drugs subject facility uses single systems in which thand a missing dose This REQUIREMENT by: Based on observative review, the facility fopened and discard This had the potent (R128, R7) with eye Findings include: On 10/15/18, at 12: medication carts or were two bottles of fumarate eye drops hand an open date drops (used to treathad an open date of had Rhopressa eye	e of Drugs and Biologicals cordance with State and acility must store all drugs and d compartments under proper ls, and permit only authorized	F 7	Immediate Plan of Correction Eye gtts were immediately re the old eye gtts were remove New eye gtts arrived from Me Pharmacy on 10/18/18. Identification of Other Reside complete audit of medication completed to ensure all medi properly dated when opened Measures Put in Place: Licensed staff and TMAs have re-educated on the policy for storage of medications. Monitoring Mechanisms: Audits will be completed on 5 medication carts weekly X 4 and the state of the policy for storage of medications.	ordered and d from cart. erwins ents: A carts will be cations are re been labeling and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG	СОМІ	(X3) DATE SURVEY COMPLETED	
		245264	B. WING_			C 18/2018	
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIF 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HE APPROPR I ATE	(X5) COMPLETION DATE	
F 761	On 10/15/18, at 12 (RN)-A verified Kedrops should not kedrops should not kedrops should not kedrops an open date written did not know how the eye drops word an open date written did not know how the eye drops word an open date written did not know how the eye drops word an open date written did not know how the eye drops situation direction. There should have medication-passing duration various in R128's physician included Durezol ophthalmic twice and drops solution (0.0 ophthalmic twice and medical administration and the desired should be an expensive desired the facility staff should be a staff sh	2:15 p.m. registered nurse stotifen fumarate and Durezol be use after being open for 28 and Rhopressa did not have an on it. RN-A further stated she facility staff would justify when all be expired if there were not sen on the medications. RN-A ere no eye drop medication and on the medication carts. The been a "cheat-sheet" on each ag cart which would indicate the medications could be used. Forders dated 6/26/2018, drops 0.05% solution one drop a day and Ketotifen Fumarate 0.25% (0.035%) one drop a day. A review of R128's ation record (MAR) indicated sceiving the drops daily. Forders dated 10/9/2018, included solution one drop in both eyes each of R7's MAR indicated R7	F 70	monthly X 2 months to enwith labeling and propers medications. Results of be reviewed by the facility committee and further more recommended by them a Person responsible for condition of nursing is responsible for compliance.	storage of these audits will y QAPI onitoring will be s indicated.		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				COMPLETED		
		245264	B. WING	;		1	C / 18/2018	
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HCC OF APPLE VALLEY					STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124	1 10/	10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)) BE	(X5) COMPLETION DATE	
F 761	open date on the minto use and staff simedications 28 day the manufacturer did on 10/18/18, at 10: (DON) confirmed his staff to write an open when put in use. The drops should be used manufacturer instruction on 10/18/18, at 1:1 fumarate drops 0.00 and Rhopressa 0.00 days after opening. Review of the facility dated 7/5/2018, did to open dates and on the staff to the facility dated 7/25/18, indicated 7/25/18,	ould have a hand written hedication container when put hould discard any eye drop a after the open date unless irected otherwise. 05 a.m. the director of nursing er expectation would be for en date on eye medication he DON confirmed the eye ed for 28 days unless the licted otherwise. DON highle box of Rhopressa 0.02% en date written on it. 9 p.m. DON stated Ketotifen 25% (0.035%), Durezol drops, 2% should be discarded 28	F	761				

PRINTED: 11/19/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A BUILDING 01 - MAIN BUILDING 01 B. WING 245264 10/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 14650 GARRETT AVENUE AUGUSTANA HCC OF APPLE VALLEY APPLE VALLEY, MN 55124 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) ID (X4) ID COMPLÉTION (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES** (K-TAGS) TO: IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: FM.HC.Inspections@state.mn.us A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Augustana Health Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) (X6) DATE TITLE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

11/10/2018

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.

PRINTED: 11/19/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
245264			B WING		10/	/17/2018	
	PROVIDER OR SUPPLIER	VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	A THE AD	HOULD BE	(X5) COMPLETION DATE	
K 000	DEFICIENCY MUSE FOLLOWING INFO 1. A description of to correct the defic 2. The actual, or proceedings of the correct the defic 3. The name and/oresponsible for comprevent a reoccurre Augustana Health of a 3-story building with building was constructed to be on the building has an installed throughout Standard for Install Systems (2010 editalarm system with the corridor system. The fire alarm system the fire alarm system of the department not accordance with Ni Alarm Code" (2010 have automatic fire	THE PLAN to: @State.mn.us RRECTION FOR EACH TINCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. oposed, completion date. or title of the person rection and monitoring to ence of the deficiency. Care Center of Apple Valley is with a full basement. The ructed in 1983, and was of Type II(222) construction. In automatic sprinkler system t in accordance with NFPA 13 ation of Automatic Sprinkler tion). The facility has a fire smoke detection throughout and in the common spaces. em is monitored for automatic ification and is installed in FPA 72 "The National Fire dedition). Hazardous areas detection that is on the fire cordance with the Minnesota	KO	000			
		apacity of 178 beds and had a e time of the survey.					

Event ID: TEQW21

PRINTED: 11/19/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 B. WING 245264 10/17/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 14650 GARRETT AVENUE AUGUSTANA HCC OF APPLE VALLEY APPLE VALLEY, MN 55124 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 Continued From page 2 K 000 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: 11/1/18 K 914 Electrical Systems - Maintenance and Testing K 914 SS=F | CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Created a list of resident rooms and The facility failed to comply with Life Safety Code outlet locations to inspect on a yearly (6.3.4 (NFPA 99) Electrical Systems - Maintenance and Testing Completed all resident room inspections This deficient practice could affect the safety of all of electrical outlets. (156) the residents with in the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245264	B. WING			10/	17/2018
	PROVIDER OR SUPPLIER	VALLEY		146	REET ADDRESS, CITY, STATE, ZIP CODE 650 GARRETT AVENUE PLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 914	reviewed revealed The Facility does noutlet testing comp This deficient pract	ervation and documentation	К	914			
K 918 SS=F	Electrical Systems CFR(s): NFPA 101 Electrical Systems Maintenance and T The generator or of and associated equivariates within 10 secriterion is not met process shall be processed in the shall be proces	- Essential Electric System esting ther alternate power source sipment is capable of supplying econds. If the 10-second during the monthly test, a ovided to annually confirm this e safety and critical branches. esting of the generator and re performed in accordance inspected weekly, exercised tes 12 times a year in 20-40 exercised once every 36 uous hours. Scheduled test ns include a complete t and automatic or manual oads, and are conducted by tel. Maintenance and testing of	K	918			11/1/18
	stored energy power accordance with NF circuit breakers are program for periodi components is esta manufacturer requirements and to the store of the	er sources (Type 3 EES) are in FPA 111. Main and feeder inspected annually, and a					

PRINTED: 11/19/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı	IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245264	B, WING_		10/	17/2018
	PROVIDER OR SUPPLIER ANA HCC OF APPLE	VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 918	separate from norm the possibility of da source is a design of installations. 6.4.4, 6.5.4, 6.6.4 (Installations) 6.4.4, 6.5.4, 6.6.4 (Installations) This REQUIREMENT by: The facility failed to (6.4.4, 6.5.4, 6.6.4 (Installations) The facility failed to (Installations) This deficient practice (Installations) This deficient practice (Installations) This deficient practice (Installations) This deficient practice (Installations) There is no emerge generator for the head of the following the following of the following the following deficient practice (Installations) This deficient practice (Installations) This deficient practice (Installations) This deficient practice (Installations)	nal power circuits. Minimizing mage of the emergency power consideration for new NFPA 99), NFPA 110, NFPA 70) NT is not met as evidenced comply with Life Safety Code (NFPA 99), NFPA 110, NFPA 70) - Essential Electric System esting ice could affect the safety of all with in the Facility. Yeen 09:00 AM and 01:00 PM ervations and staff interview	K 91	Hired a licensed electrical technic install a Red push to shut off switc generator, located at head end sw panel (Transfer switch) Put in place clearly marked sign no switch that indicates emergency poshut off.	ch for itch ext to	

Facility ID: 00979



Protecting, Maintaining and Improving the Health of All Minnes ot ans

Electronically delivered November 2, 2018

Administrator Augustana Hcc Of Apple Valley 14650 Garrett Avenue Apple Valley, MN 55124

Re: State Nursing Home Licensing Orders - Project Numbers S5264029, H5264074, and H5264075

Dear Administrator:

The above facility was surveyed on October 15, 2018 through October 18, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5264074 and H5264075. 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 <u>only a suggestion</u> 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

Augustana Hcc Of Apple Valley November 2, 2018 Page 2

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

1 Julius Stapson

Health Regulation Division

PRINTED: 11/26/2018 FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING 00979 10/18/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE **AUGUSTANA HCC OF APPLE VALLEY** APPLE VALLEY, MN 55124 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****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.

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/inf obul.htm The State licensing orders are delineated on the attached Minnesota

Minnesota Department of Health

INITIAL COMMENTS:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/12/18

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER:

A. BUILDING:

C

C

B. WING

10/18/2018

	00979		B. WING	10/18/2018		
	PROVIDER OR SUPPLIER			DRESS, CITY, S	TATE, ZIP CODE	
AUGUST	ANA HCC OF APPLE	VALLEY		ALLEY, MN		
(X4) ID PREFIX TAG		TEMENT OF DEFICI Y MUST BE PRECED SC IDENTIFYING IN	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLET
		age 1 age 1 age 1 alth orders being Although no plate Statutes/Rurected" in the beindicate in the cess, under the dedate your ordectronically subnent of Health. agh 10/18/18, subvisited the above tion orders are your electronic phave reviewed the when they will be the dedate when they will be the dedate the dedate when they will be the dedate the	g submitted to an of correction les, please ox available for electronic heading ers will be omitting to the reprovider and issued. Dan of these orders, li be seed documenting ders using the been estrules for the seed or th		CROSS-REFERENCED TO THE APPROP	
	An investigation of complaint's H5264074 and H5264075 were completed. The complaints were substantiated. Correction order(s) issued at State Licensing 1545, and 0830. 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					

Minnesota Department of Health

STATE FORM TEQW11 If continuation sheet 2 of 54

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00979	B. WING		1	2 8/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VALLEY	ARRETT AVEN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	after the statement, evidence by." Follo are the Suggested Time period for Cor PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA THERE IS NO REC PLAN OF CORRECT	"This Rule is not met as wing the surveyors findings Method of Correction and rection." RD THE HEADING OF THE	2 000			
2 335	Records A current personne for each employee manner. The person most recent three-y maintained by the right must be available to department and must be available to depart and person and precords; and precords; and precords; and but the date of right beautiful and the date of the	nursing home. The records or representatives of the	2 335			11/29/18

6899

Minnesota Department of Health STATE FORM

TEQW11 If continuation sheet 3 of 54

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00979	B. WING		10/1	; 8/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VALLEY	ARRETT AVE ALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 335	Continued From pa	ge 3	2 335			
		art 4605.7040, must be red in a separate employee				
	by: Based on interview facility failed to comevaluations (PE) fo	and document review, the aplete annual performance r 4 of 5 nursing assistants D, NA-E) who had worked at a year.		See plan of correction for corresp Federal tag.	onding	
	Findings Include:					
	Review of NA person revealed the following	onnel files on 10/18/18, ng:				
		(DOH) with the facility was E completed by the facility was	3			
	NA-C's DOH with the last PE completed v	ne facility was 6/20/17, and was 8/31/17.				
	NA-D's DOH with the last PE completed v	ne facility was 10/2/89, and was 8/7/15.				
	NA-E's DOH with the PE completed was	ne facility was 5/8/15, and last 9/8/17.				
	Nursing (IDON) ver NA-E's last PE date nurse managers co expected them to b year after the last F or after". IDON con NA-E's PEs were n	9 p.m. Interim Director of ified NA-B, NA-C, NA-D and completed. IDON stated the impleted the PEs and she e completed "yearly", one PE completed "30 days before firmed NA-B, NA-C, NA-D and ot current, and had not been DON also confirmed Human				

Minnesota Department of Health

STATE FORM TEQW11 If continuation sheet 4 of 54

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED	
			A. BOILDING:			2
		00979	B. WING			18/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AUGUS1	ANA HCC OF APPLE	VALLEY	ARRETT AVE ALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 335	Continued From pa	ige 4	2 335			
	Resources had no other PEs completed for NA-B, NA-C, NA-D and NA-E. Facility policy dated Revision 11/15 Performance Evaluation Policy indicated, " Employee performance evaluations shall be conducted yearly" SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could review and /or revise policies and procedures to ensure the facility evaluated staff performance. The DON or designee could develop monitoring systems to ensure ongoing compliance and report the results to the quality assurance committee for further recommendations.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 1 Adequate and re; General	2 830			11/29/18
	receive nursing car custodial care, and individual needs and the comprehensive plan of care as des and 4658.0405. A be out of bed as muis a written order from the custodial care.	general. A resident must e and treatment, personal and supervision based on a preferences as identified in resident assessment and scribed in parts 4658.0400 nursing home resident must uch as possible unless there om the attending physician ust remain in bed or the remain in bed.				
	This MN Requireme	ent is not met as evidenced				

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PRINTED: 11/26/2018 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING 00979 10/18/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE **AUGUSTANA HCC OF APPLE VALLEY** APPLE VALLEY, MN 55124 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 830 Continued From page 5 2 8 3 0 by: See POC for corresponding Federal tag. Based on observation, interview and document review, the facility failed to ensure a comprehensive assessment, ongoing monitoring and evaluation for safe smoking was completed for 1 of 1 resident (R455) reviewed for smoking and failed to ensure the dialysis access site was assessed and a person centered plan of was developed for 1 of 2 residents (R134) reviewed for dialysis. In addition the facility also failed to ensure ongoing physical and verbal behaviors were comprehensively assessed, person centered individualized non-pharmacological interventions were developed, and failed to determine whether outside professional help was necessary for 1 of 5 residents (R129) reviewed for dementia care, who demonstrated increased physical and verbal behaviors causing distress to themselves and others. Findings include: R455's resident face sheet printed on 10/17/18, indicated R455 was admitted to the facility on 9/29/18, and diagnoses included back pain, nicotine dependence and generalized muscle weakness. During an initial entrance conference interview on 10/15/18, the administrator stated there were no

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current smokers residing in the facility.

During observation and interview on 10/15/18, at 2:09 p.m. R455 was observed to have an open pack of cigarettes and a lighter on his bedside table in his room. R455 stated that he smoked and independently wheeled himself, while in wheelchair, to the street as the facility was smoke free. R455 indicated that he was able to

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R455 as a "smoker or history of smoking." However, the individualized care plan lacked evidence of interventions related to R455's

R455's nurse progress noted dated 9/30/18, indicated "Pt [patient] is a smoker and does know we are smoke free and needs to go off property

smoking and/ or smoking history.

to smoke pt did x [times] 2."

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00979	B. WING		10/1	; 8/2018
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
AUGUST	ANA HCC OF APPLE	VALLEY	RRETT AVE ALLEY, MN			
(X4) I D PREF I X TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From page 7		2 830			
		ord was reviewed on m. and lacked evidence of a nt.				
	RN-F verified there believed to smoke i identified the reside the facility electroni	on 10/15/18, at 3:44 p.m. was a resident who she residing on the unit. RN-Fent to be R455. RN-F reviewed c medical record and revealed a smoking risk observation				
	During a follow-up interview on 10/17/18, at 12:45 p.m. RN-F confirmed R455 did smoke, however she identified R455 "goes off of the property to smoke."					
	director of nursing (expectation that a s completed for any r planned. The DON would need to have with the ability to le Furthermore, the D	10/18/18, at 10:34 a.m. the (DON) stated it was her smoking assessment be resident who smoke, and care further indicated the resident e had a cognitive assessment ave the premises to smoke. ON verified that cigarette and ked in storage at the nurse				
	10/2017, indicated will be offered smol prior to being allow campus, resident with the Augustana Clie to determine if this observation will be quarterly, with signipers (as needed). I	moking resident effective date "residents desiring to smoke king cessation methods, ed to sign out to go off will be assessed by staff using nt Smoking Risk observation would be a safe option. The completed on admission, ficant change in status and ndividualized approaches and will be documented in the				

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R134's Care Area Assessment (CAA) dated 10/5/18, identified R134 received dialysis however, lacked documentation of R134's hemodialysis central venous catheter ([CVC] intravenous access for dialysis which goes directly into the heart and is at risk for infection) and required monitoring of the CVC (drainage, bleeding, ensure dressing remained intact and area remained dry).

disease and identified R134 admitted to the

facility on 9/28/18.

On 10/16/18, at 8:54 a.m. R134 was observed and interviewed. R134 stated she received dialysis three times a week from a dialysis clinic in a neighboring town. She stated she had a CVC in her right upper chest wall. R134 further stated she had to stop the facility nurses from removing her dressing covering the CVC. R134 pulled down the collar of her shirt and revealed a transparent dressing which covered the port into R134's chest wall with three lumens extended from the port that were covered and wrapped in gauze. R134 further confirmed that the dressing over the CVC was only to be changed at the dialysis clinic, R134 was unable to recall how many times the nurses had attempted but did recall there was a few times since admission.

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evening shift after return from dialysis.

During phone interview on 10/17/18, at 9:41 a.m. with R134's dialysis clinic, the clinic manager verified R134 had a right upper chest CVC. The clinic manager further stated that all dressings covering the CVC were to remain clean, dry and intact and dressings were only to be changed by

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | (X3) DATE SURVEY COMPLETED | (X4) DATE SURVEY COMPLETED | (X5) DATE SURVEY COMPLETED | (X6) DATE SURVEY COMPLETE

	ANA HCC OF APPLE VALLEY 14650	GARRETT AVE	DRESS, CITY, STATE, ZIP CODE RRETT AVENUE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
2 830	Continued From page 10 the dialysis clinic staff. The clinic manager furth verified R134 did not have a dialysis fistula. During interview on 10/17/18, at 12:37 p.m. RN-G identified the dialysis access port was on the care plan, however, verified the dialysis access port was not found within the CAAs. RN-G stated the dialysis access site location a information was gathered from the physician orders and resident progress notes. During interview on 10/17/18, at 2:24 p.m. RN-reviewed R134's dialysis care plan and physicion orders. RN-I acknowledged R134's dressing we to be removed before bed after dialysis on dialysis days and a bruit was to be assessed every shift. RN-I verified a bruit would not be heard with a CVC. RN-I revealed that within the facility electronic medical record, there were dialysis care protocol orders that had been automatically populated for R134. RN-I further stated these were standard orders and would need to be personalized following each resider assessment. Furthermore, RN-I verified R134 have a CVC and indicated it was her expectation for an assessment of a resident's dialysis clinic with concerns. During interview on 10/18/18, at 10:37 a.m. director of nursing (DON) stated it was her expectation for an assessment of a resident's dialysis access site to be completed upon admission The DON further stated the nurse would need to obtain accurate orders for dialysis access site care following the completed assessment.	nd II, ian ias e				
	During interview on 10/18/18, at 12:29 p.m. RN stated she was unable to locate a dialysis	I-F				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3)			(3) DATE SURVEY COMPLETED	
		00979	B. WING		10/1	8/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
AUGUST	ANA HCC OF APPLE	VALLEY	RRETT AVE ALLEY, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 11	2 830				
	assessment.						
	identified "1. Resider receivecomprehe of care. 2. Facility vassessment of the R129 quarterly min assessment dated of dementia. This qwas unable to be it was rarely/never urassessed as having memory deficits an including difficulty for distractible, and difficulty for distractible and value of the required supervision.	resident's condition" imum data set (MDS) 7/11/18, included a diagnosis uarterly MDS indicated R129 nterviewed because R129 nderstood. R129 was g both long and short term d inattentive behaviors ocusing attention, being easily ficulty keeping track of what havioral symptoms included rerbal behaviors occurring 1-3 ook back period. The MDS 9 was hard of hearing, and n with some activities of daily bendent with walking using a					
	alteration in behaviorelated to the diagnostic being hard of hearing one new intervention staff were to re-appose behaviors were included offer times re-approaching. R1 a problem with alter R129 as severely in Nursing Assistant C	e plan included a potential or originally identified 8/15/14, oses of dementia, anxiety and ng. The care plan included on initiated 9/21/18, indicating broach R129 as needed when reased. Other interventions for R129 to calm down before 29's care plan also indicated ration in cognition, identifying mpaired. R129's undated care Sheet identified tions including notifying s toward spouse,					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00979	B. WING		10/1) 8/2018
	PROVIDER OR SUPPLIER	VALLEY 14650 GA	DRESS, CITY, S RRETT AVEI			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	re-approach, and k safety checks at night safety safe	eep room orderly, 30 minute ght and report refusal of cares. ion on 10/15/18, at 6:28 p.m. d in his room with a distressed vaving his hands, standing vas sitting in a wheelchair next her pants are too tight." The at no staff were observed. The surveyor alerted staff to d an unidentified staff person ion on 10/16/2018, at 2:32 wife were observed heading om to play BINGO. Family as present and R129 gitated behaviors. During an at 3:50 p.m., FM-E stated cility would be happy if her neger residents of the nursing she had received a explaining the risks of R129's rents stay at the facility. FM-E acreased behavior, the ad had pictures of blood on the ner had fallen. FM-E also brother had stayed over at the ats in the past, and stated she 129's behavior is due to staff note on 7/3/18, the physician naving behaviors that were not resulting in some distress to olan was to increase from 250 mg (milligrams) at in the morning and 250 mg at	2 830			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00979	B. WING		10/1) 8/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
ALICHET	TANA LICC OF ARRIE	14650 GA	RRETT AVEI			
AUGUSTANA HCC OF APPLE VALLEY APPLE V			ALLEY, MN	55124		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OULD BE COMPLETE	
2 830	Continued From pa	ge 13	2 830			
	used to treat challe (milligrams) at bedfi received from the president's Depaker each morning, in at The order specified was to be updated behaviors in 2 wee inadvertently stopp Following the discouthe nursing progres 9/15/18, revealed a including refusing of medications; combi punching and biting staff; pounding his room; pounding on charge at staff; refulegs; not letting star police; trying to get to get wife into bed and standing lift for angry; grabbing star would not let go; aginjury to head. Ever were documented, facility interdisciplin reassessed R129's needs, re-assessed interventions, dever individualized non-and/or sought outsipsychologist and/or R129's dementia rebehavioral needs.	ed the Depakene on 7/17/18. Intinuation of the Depakene, is notes from 7/24/18 through in increase in behaviors cares, baths and taking ative towards staff; hitting, is staff; swearing and yelling at wheelchair on the floor in his the wall; swing walker at staff; using dressing change to his if help wife, wanting to call the wife out of her chairs, trying, while she needed two persons transfers; pacing in room; iff ans spouse by arms and gitation that led to fall with in though these behaviors there was no evidence the lary team comprehensively individualized dementia care				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | (X4) MULTIPLE CONSTRUCTION | (X5) MULTIPLE CONSTRUCTION | (X6) MULTIPLE CONSTRUCTION | (X6) DATE SURVEY COMPLETED | (X6) DATE SURVEY COMPLETE

	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
2 830	Continued From page 14 9/11/18, listed R129's medications and did include Depakene. Under assessment and NP indicated a diagnosis of dementia with behavioral and psychological symptoms of dementia (BPSD) that "staff approach in I hearing impairment matters. Certainly, also continue mood stabilizer." Progress note dated 9/19/18, at 2:27 p.m. indicated a family meeting was held to dis R129's continued behaviors. Family believe R129 behaviors can be managed with appropriate medication. Family talked about frustration with staff approach and the lack anticipation of needs. Family is not open to the night as they are still recovering from the night as they are still recovering from the couple to a new facility as they believe it create more risk for the couple. It is not open to separating the couple as the believe it would only lead to more behavion has restarted Depakote and will slowly incontrol. There was no evidence of addition non-pharmacological interventions develothe interdisciplinary (IDT) team, or request to have R129 be evaluated by outside professional services such as a psychologopsychiatrist. The medication error with the Depakene we discovered on 9/20/18, by registered nurse (RN)-C while investigating R129's fall. The evaluation portion of the medication error acknowledged an increase in R129's behaving the time of discontinuation.	I not d plan f ight of o cuss /es ut c of o stay doing sfer to / amily ey rs. NP crease nder nal ped by t made gist or vas e e creport	TAG 2 830		DATE		
	During an interview on 10/17/18 at 10:53 a NA-H stated R129 was agitated at the time						

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diagnosed with dementia, receives the

mental and psychosocial well-being.

appropriate treatment and services to attain or maintain his or her highest practicable physical,

A facility's Behavioral Health Services policy dated 6/28/18, indicated facility staff will identify.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			X3) DATE SURVEY COMPLETED	
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2 830	document and infordetails regarding of behavior. New or convill be evaluated by order to help determ to address any more contributed to the results of the director of nursidevelop, review, and procedures to ensurassessed residents dialysis site care and designee could devenoure ongoing corresults to the qualit further recommend	rm the provider about specific nanges in an individual's hanging behavioral symptoms y the interdisciplinary (IDT) in mine the underlying cause and diffiable factors that may have esident's change in condition. THODS OF CORRECTION: sing (DON) or designee could not /or revise policies and are the facility properly is for safe smoking procedures, and dementia care. The DON or welop monitoring systems to impliance and report the y assurance committee for	2 830			
2 885	Nursing Care; Prog Subpart 1. Programmust have an active nursing care directoresident to achieve practicable physical well-being according resident assessme in parts 4658.0400 efforts must be made and purposeful active.	m required. A nursing home e program of rehabilitation ed toward assisting each and maintain the highest and mental, and psychosocial ag to the comprehensive nt and plan of care described and 4658.0405. Continuous de to encourage ambulation	2 885			11/29/18

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00979		B. WING		C 10/18	3/2 01 8
	PROVIDER OR SUPPLIER	VALLEY	14650 GA	DRESS, CITY, S IRRETT AVE ALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCE MUST BE PRECEDED E SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION SHOULD BE COMPLÉ: THE APPROPRIATE DATE	
2 885	Based on observatireview, the facility freeliew, the facility freeliew, the facility freeliew for 2 of 4 reviewed for rehabit Findings include: R85's quarterly Min 9/11/18, indicated Freeded limited staff walking in room and (meaning not assess change MDS dated needed limited staff walked in her room supervision. R85's careplan date staff were to walk Freeded limited staff walked in her room supervision. R85's careplan date staff were to walk Freeded limited staff walker two times day physical therapy and the supposed to ge "almost always" ware R85 stated nursing her he was "too bus she was "going dow R85 stated she was down the hall as far and the distance keews also attending exercises. On 10/17/18, at 1:0 (RN)-A stated R85 for the same stated R85 for the sa	on, interview and cailed to provide resestidents (R85, R11 litation. imum Data Set (MI R85's cognition was f assistance to trand corridor was marked). R85's signific 6/18/18, indicated f assistance with trand in the corridor and in the corridor ded 3/29/18, indicated assistance with trand in the hallway unally to maintain gair d R85 ambulated as not walked in the assistant (NA)-C was walked two times as not walked in the assistant (NA)-C was to walk her. R85 on hill" from not being supposed to be well as she could go the put track of. R85 states and the response of the supposed to be well as she could go the put track of the supposed to be well as she could go the put track of the supposed to be well as she could go the put track of the supposed to be well as she could go the put track of the supposed to be well as she could go the put track of the supposed to be well as she could go the put track of the supposed to be well as she could go the put track of the supposed to be well as she could go the put track of the supposed to be well as she could go the put track of the supposed to be well as she could go the put track of the supposed to be well as she could go the put track of the supposed to be well as she could go the put track of the supposed to be well as she could go the put track of the supposed to be well as she could go the supposed to be well as she could go the supposed to be well as she could go the supposed to be well as she could go the supposed to be well as she could go the supposed to be well as she could go the supposed to be well as she could go the supposed to be well as she could go the supposed to be well as she could go the supposed to be well as she could go the supposed to be well as she could go the supposed to be well as she could go the supposed to be well as she could go the supposed to be well as she could go the supposed to be well as she could go the supposed to be well as she could go the supposed to be well as she could go the supposed to be well as she could go the supposed	DS) dated intact, sfer and ked as a"-" cant R85 ansfers and with staff ed nursing using as made in 15-30 feet. Liveyor she is a day but mornings. Vould tell is stated and with staff ed hening walked.	2 885	See plan of correction for corresp Federal tag.	onding	
	for walking and also stated R85 was doi therapy had gotten	o attended therapy. ng a lot better now	RN-A since				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION

A. BUILDING: ______

С

(X3) DATE SURVEY COMPLETED

		00979	B. WING		C 10/18/2018
	PROVIDER OR SUPPLIER	VALLEY 14650 GA	DRESS, CITY, S RRETT AVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
2 885	Review of R85's Podated 9/1/18-10/18, documented "Not Pdocumented by NAs. On 10/18/18, at 12: weakness in her legown, and could now looked at the Point computer from 10/1 stated it looked like every morning. Bas been completed the "Not Performed" fiv "unanswered" ten ti walking was a part program to be compand had been unaw walked every morning. On 10/18/18, at 12: a walking program morning as far as s NA-G stated R85 shad improved with refused to walk. NA walk in her room will and from the bathrost	ge 18 pint of Care History for walking (18, indicated 25 x NAs Performed", 46 x NAs Swered" and 24 x documented (24 p.m. RN-B stated R85 had gs, wanted to walk on her walk short distances. RN-B of Care documentation on the (0/18, through 10/18/18, and R85 was not being walked ged on data walking had only gree times (times), documented gree times (times), documented gree times, and documented gree times (times) and documented gree R85 was not being gree R85 was not be	2 885		
	on a walking progra days 50 feet or mor walk R85 in the mo do that when less the	1 p.m. NA-C stated R85 was am and could walk on some re. NA-C stated he tried to rnings but could not always nan full staffed. NA-C stated when he could not walk R85			

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PRINTED: 11/26/2018 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING 00979 10/18/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE **AUGUSTANA HCC OF APPLE VALLEY** APPLE VALLEY, MN 55124 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 885 Continued From page 19 2 885 and the nurses reply were, "try to get it done." NA-C stated R85, "did not refuse at all to walk, rarely, she would have to be sick" to refuse. On 10/18/18, at 2:00 p.m. Interim Director of Nursing (IDON) stated she expected nursing staff to complete rehabilitation programs with the residents and if unable to complete the task staff were expected to notify the nurse and nurse would evaluate the concern. During an interview on 10/15/18 at 5:07 p.m., R114 stated she did not have use of her right arm and although she had physical therapy (PT) and occupational therapy (OT) she had not received range-of-motion from the nursing assistants every evening at bedtime. R114 explained it depended on which staff was scheduled on the p.m. shift and not all staff were knowledgeable on the procedure. R114's Face Sheet, printed 10/18/18, noted diagnoses including: functional quadriplegia, multiple sclerosis (MS, pain, muscle spasm, restless lea syndrome related to MS. hemipleaia. unspecified osteoarthritis and muscle weakness. The Minimum Data Set (MDS) dated 1/15/18. verified R114 did not have dementia and had no adverse behaviors, memory loss or changes in mental status noted, and R114's cognition was

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intact. The Care Assessment Area (CAA) dated

regarding need for restorative nursing (PROM).

The Augustana Care and Health Rehab Sheet, Group 6 of 8, dated 10/1/18, directed staff to provide Passive ROM daily for R114. The undated Resident Sheet (NA assignment sheet)

1/15/18, did not include any information

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

С 10/18/2018

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B. WING _

A. BUILDING:

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NAME OF F	PROVIDER OR SUPPLIER STREET ADD	DRESS, CITY, S	STATE, ZIP CODE	
AUGUST	ANA HCC OF APPLE VALLEY	RRETT AVE		
	APPLE VA	ALLEY, MN		
(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) COMPLETI DATE
2 885	Continued From page 20	2 885		
	also verified R114 was to receive passive ROM (PROM) daily at bedtime.			
	R114's Care Plan, last reviewed/revised 10/17/18, directed staff to perform ROM daily at bedtime and included hip flexion, knee extension, ankle dorsi flexion, plantar flexion, hip abduction and log roll.			
	The Augustana Health and Rehabilitation -Apple Valley Point of Care History Sheets, dated 9/1/18 through 10/18/18, verified R114 received PROM services from staff 16 of 34 times during this period.			
	The Physical Therapy Recert (recertification) Progress Report and Updated Treatment Plan, certification period 10/11/18 through 11/9/18, noted PT would set up with more appropriate RNP (Restorative Nursing Program) for ROM with staff with at least 75% carryover by staff in order to maximize benefits and decrease pain and spasming on a daily basis without use of medication interventions. The report also indicated R114 was receiving carryover by staff about 50% of their scheduled time. The Occupational Recert Progress Report and Updated Treatment Plan, certification period 10/1/18 through 10/30/18 Instructions for Patient and Caregiver Training verified patient education on ROM to be done in R114's room to prevent any further contractures to upper and lower extremities. The report also noted R114 was compliant and participated in ROM and strengthening exercises to allow continued participation in her activities of daily living.			
	On 10/17/18 at 1:31 p.m. the director of therapy clarified R114 was seen by therapy twice each			

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PRINTED: 11/26/2018 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING 00979 10/18/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE **AUGUSTANA HCC OF APPLE VALLEY** APPLE VALLEY, MN 55124 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 885 Continued From page 21 2 885 week and in addition received general PROM daily to all extremities on the evening shift. On 2017 at 2:10 p.m., RN-B verified the current care plan included daily restorative nursing directives and added she absolutely expected the nursing assistants complete PROM for R114 as it is in the current care plan and their assignment sheets. She also stated that the care plan indicated there were directions in R114's room for PROM/Exercise. RN-B proceeded to R114's room but did not find documentation /direction or guidance to perform PROM or exercise for R114. During an interview on 10/18/18, at 1:10 p.m., the interim director of nursing (IDON) stated she expected staff to complete all cares and services as directed on the care plan. She further stated if staff was not performing ROM for R114, she would expect staff to report why it was not performed. The IDON concluded, "The facility had monthly meetings regarding restorative nursing, but nobody is making notes. We are looking to change this."

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assistance.

The Augustana Restorative Nursing Programs/ Functional Maintenance Programs Policy and Procedure, revised 11/2017, noted the facility would provide appropriate and necessary programming designed to meet needs, meaning physical, mental, and psychosocial well being of each individual resident. Responsible Person: nursing therapy, restorative nursing/nursing

SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00979	B. WING		10/1	8/2018
	PROVIDER OR SUPPLIER	VALLEY 14650 GA	DRESS, CITY, S RRETT AVE ALLEY, MN			
(X4) I D PREF I X TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 885	residents' on staff a programs based or assessed needs. T conduct audits of rewalking programs to consistently.	age 22 assisted rehabilitation nursing a residents' comprehensively he DON or designee could esidents on staff assisted o ensure their needs are met	2 885			
2 910	Incontinence Subp. 5. Incontinent have a continuous management to recunnecessary use of comprehensive reshome must ensure A. a resident without an indwelling unless the resident that catheterization B. a resident with receives appropriate prevent urinary trace	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: the enters a nursing home ag catheter is not catheterized is clinical condition indicates was necessary; and no is incontinent of bladder the treatment and services to ct infections and to restore as er function as possible.	2 910			11/29/18
	by: Based on observation review, the facility fassess toileting new interventions were (R453) reviewed for	ent is not met as evidenced ion, interview and document ailed to comprehensively eds to ensure appropriate provided for 1 of 5 residents in bladder continence, and who is catheterization to drain		See plan of correction for corresp Federal tag.	onding	

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00979	B. WING		10/1	8/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VALLEY	RRETT AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 23	2 910			
	bladder from urine.					
	Findings include:					
	R453 stated that she since her surgery in (a tube used to drain R453 further stated to "empty her bladding (10/13/18) arout (unable to identify) complete the catheterization output was almost a Furthermore, R453 spoken with the proday(10/15/18) and a [PVR] the amount of using the restroom) hours instead of evensure she would have often.	verbalized that she had byider earlier in the asked for post void residual (of urine left in the bladder after to be checked every six ery six hours as needed to have her bladder checked				
	indicated R453 adn	ace Sheet printed on 10/18/18, nitted to the facility on noses included cervical disc c kidney disease.				
	indicated "Patient n catheterization ever	dmission orders 10/11/18, nay need straight intermittent ry six hours as needed." cian admission orders lacked I parameters.				
		ers from the hospital dated under discharge instructions straight intermittent				

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PRINTED: 11/26/2018 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING 00979 10/18/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE **AUGUSTANA HCC OF APPLE VALLEY** APPLE VALLEY, MN 55124 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 910 Continued From page 24 2 9 1 0 catheterization every 6 hours" and included R453's discharge diagnoses to be cervical myelopathy (compression on the cervical spinal cord) and neurogenic bladder (bladder

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During an interview on 10/16/18, at 3:43 p.m. registered nurse (RN)-D stated R453 would verbalize when she was distended and needed to have her PVR checked. RN-D indicated all PVRs and output were recorded in the nurse progress notes.

dysfunction).

During an interview on 10/17/18, at 8:38 a.m. R453 stated she had not been able to urinate since her surgery on 9/15/18. R453 indicated while in the hospital she had been catheterized in order to empty her bladder.

During interview on 10/17/18, at 8:52 a.m. nursing assistant (NA)-A stated R453 had not urinated since admission. NA-A indicated R453 was on an every two hours toileting program, staff to offer use the toilet program and if R453 was unable to urinate the nurse was to be notified.

During interview on 10/17/18, at 12:47 p.m. RN-F reviewed R453's PVR order dated 10/15/18, and stated that the nurse would need to check R453's PVR and catheterize if there was over 350 ml of urine in R453's bladder. RN-F indicated R453's PVR results would be documented on the treatment administration record (TAR).

During interview on 10/18/18, at 9:00 a.m. R453's nurse practitioner (NP) stated she was made aware during visit with R453 on 10/15/18 that R453 felt that she had waited too long to be

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND FLAN OF CORRECTION IDENTIFICATION NUMBER. A. BUILDING:	С
	(.
00979 B. WING 10	/18/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
AUGUSTANA HCC OF APPLE VALLEY 14650 GARRETT AVENUE APPLE VALLEY, MN 55124	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
DEFICIENCY)	
catheterized. The NP indicated that she scheduled R453's PVRs for every 6 hours and as needed per R453's indication. The NP confirmed it would have been expected for R453's PVRs to be monitored every shift and/ or every six hours. The NP reviewed "call notes" and stated she was not made aware of any delay in completion of R453's PVRs or catheterizations. R453's care plan revised 10/16/18, indicated R453 was continent of bladder and to provide pericare after incontinent episodes and indicated to assist with toileting every two hours. R453's care plan lacked evidence of R453's need to be catheterized, PVRs completed and did not address R453's diagnosis of neurogenic bladder. R453's nurse progress notes and TAR were reviewed from 10/12/18 to 10/16/18: -On 10/13/18, at 9:00 p.m. the note indicated R453 was catheterized and had 640 ml of urine output; -On 10/14/18, at 9:54 a.m. the TAR indicated R453 was catheterized and had 525 ml of urine output; -On 10/14/18, at 15:30 p.m. the note indicated R453 was catheterized and had 625 ml of urine output; -On 10/14/18, at 11:32 p.m. the TAR indicated R453 was catheterized and had 625 ml of urine output; -On 10/14/18, at 11:32 p.m. the TAR indicated R453 was catheterized and had 625 ml of urine output; -On 10/16/18, at 11:32 p.m. the TAR indicated R453 was catheterized and had 600 ml of urine output; -On 10/16/18, at 11:32 p.m. the TAR indicated R453 was catheterized and had 600 ml of urine output; -On 10/16/18, at 11:32 p.m. the TAR indicated R453 was catheterized and had 600 ml of urine output; -On 10/16/18, at 11:32 p.m. the TAR indicated R453 was catheterized and had 600 ml of urine output; -On 10/16/18, at 11:32 p.m. the 73 indicated R453 was catheterized and had 600 ml of urine output; -On 10/16/18, at 2:34 p.m. R453's nurse progress notes and TAR lacked evidence of every six hour ongoing assessment of R453's bladder status.	

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00979	B. WING		10/1	2 8/2018
	PROVIDER OR SUPPLIER	VALLEY 14650 GA	RRETT AVE			
		APPLE V	ALLEY, MN	55124		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 26	2 910			
	interim director of n her expectation for	10/18/18, at 10:44 a.m. the dursing (IDON) stated it was the nurse to assess R453's ast one time during their ur shift.				
		35 a.m. R453's bladder equested and not provided.				
	revised date 5/2017	Catheter: Straight/ Indwelling 7, indicated "straight erformed torelieve urinary				
	The director of nursidevelop, review, an procedures to ensurassessed residents bladder manageme could develop monongoing compliance.	THODS OF CORRECTION: sing (DON) or designee could not /or revise policies and are the facility properly of for urinary retention and ent. The DON or designee itoring systems to ensure the and report the results to the committee for further				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21545	MN Rule 4658.132	0 A.B.C Medication Errors	21545			11/29/18
	percent as describe Guidelines for Code 42, section 483.25 the State Operation	ust ensure that: on error rate is less than five ed in the Interpretive e of Federal Regulations, title (m), found in Appendix P of ns Manual, Guidance to -Term Care Facilities, which is				

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STATE FORM TEQW11 If continuation sheet 27 of 54

PRINTED: 11/26/2018 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING 00979 10/18/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **14650 GARRETT AVENUE AUGUSTANA HCC OF APPLE VALLEY** APPLE VALLEY, MN 55124 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21545 Continued From page 27 21545 incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error

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that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.

This MN Requirement is not met as evidenced

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Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER AUGUSTANA HCC OF APPLE VALLEY STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE APPLE VALLEY, MN 55124 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 28 by: Based on observation, interview, and document review, the facility failed to ensure 1 of 5 residents (R129) reviewed for dementia care was free of significant medication error when order for Depakene (medication used to treat seizures and challenging behaviors) was not transcribed into the electronic medical record (EMR) according to the physician's orders. This resulted in actual harm for R129, who didn't receive the medication for 63 days, had increased agitation, and fell sustaining a laceration requiring emergency care. Findings include:	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER AUGUSTANA HCC OF APPLE VALLEY (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21545 Continued From page 28 by: Based on observation, interview, and document review, the facility failed to ensure 1 of 5 residents (R129) reviewed for dementia care was free of significant medication error when order for Depakene (medication used to treat seizures and challenging behaviors) was not transcribed into the electronic medical record (EMR) according to the physician's orders. This resulted in actual harm for R129, who didn't receive the medication for 63 days, had increased agitation, and fell sustaining a laceration requiring emergency care. Findings include:				A. BUILDING.			
AUGUSTANA HCC OF APPLE VALLEY APPLE VALLEY, MN 55124			00979	B. WING		_	
AUGUSTANA HCC OF APPLE VALLEY (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21545 Continued From page 28 by: Based on observation, interview, and document review, the facility failed to ensure 1 of 5 residents (R129) reviewed for dementia care was free of significant medication error when order for Depakene (medication used to treat seizures and challenging behaviors) was not transcribed into the electronic medical record (EMR) according to the physician's orders. This resulted in actual harm for R129, who didn't receive the medication for 63 days, had increased agitation, and fell sustaining a laceration requiring emergency care. Findings include:	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Deficiency Must be preceded by Full REGULATORY OR LSC IDENTIFYING INFORMATION) Deficiency Must be preceded by Full Regulatory or LSC IDENTIFYING INFORMATION) Deficiency Must be preceded by Full Regulatory or LSC IDENTIFYING INFORMATION) Deficiency Must be preceded by Full Regulatory or LSC IDENTIFYING INFORMATION) Deficiency Must be preceded by Full Regulatory or LSC IDENTIFYING INFORMATION) Deficiency Must be preceded by Full Regulatory or LSC IDENTIFYING INFORMATION) Deficiency Must be preceded by Full Regulatory or LSC IDENTIFYING INFORMATION) Deficiency Must be preceded by Full Regulatory or LSC IDENTIFYING INFORMATION Deficiency Must be preceded by Full Regulatory or LSC IDENTIFYING INFORMATION) Deficiency Must be preceded by Full Regulatory or LSC IDENTIFYING INFORMATION) Deficiency Must be preceded by Full Regulatory or LSC IDENTIFYING INFORMATION) Deficiency Must be preceded by Full Regulatory or LSC IDENTIFYING INFORMATION) Deficiency Must be preceded by Full Regulatory or LSC IDENTIFYING INFORMATION) Deficiency Must be preceded by Full Regulatory or LSC IDENTIFYING INFORMATION) Deficiency Must be preceded by Full Regulatory or LSC IDENTIFYING INFORMATION) Deficiency Must be preceded by Full Regulatory or LSC IDENTIFYING INFORMATION) Deficiency Must be preceded by Full Regulatory or LSC IDENTIFY INFORMATION Deficiency Must be preceded by Full Regulatory or LSC IDENTIFY INFORMATION Deficiency Must be preceded by Full Regulatory or LSC IDENTIFY INFORMATION Deficiency Must be preceded by Full Regulatory or LSC IDENTIFY INFORMATION Deficiency IDENTIFY IDENTIFY INFORMATION Deficiency IDENTIFY INFORMATION Deficiency IDENTIFY IDENTIFY INFORMATION Deficiency IDENTIFY IDENTIFY I	AUGUST	TANA HCC OF APPLE	VALLEY				
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21545 Continued From page 28 by: Based on observation, interview, and document review, the facility failed to ensure 1 of 5 residents (R129) reviewed for dementia care was free of significant medication error when order for Depakene (medication used to treat seizures and challenging behaviors) was not transcribed into the electronic medical record (EMR) according to the physician's orders. This resulted in actual harm for R129, who didn't receive the medication for 63 days, had increased agitation, and fell sustaining a laceration requiring emergency care. Findings include:	(V4) ID	SLIMMARY STA			T	ON	(V5)
by: Based on observation, interview, and document review, the facility failed to ensure 1 of 5 residents (R129) reviewed for dementia care was free of significant medication error when order for Depakene (medication used to treat seizures and challenging behaviors) was not transcribed into the electronic medical record (EMR) according to the physician's orders. This resulted in actual harm for R129, who didn't receive the medication for 63 days, had increased agitation, and fell sustaining a laceration requiring emergency care. Findings include:	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	COMPLETE DATE
Based on observation, interview, and document review, the facility failed to ensure 1 of 5 residents (R129) reviewed for dementia care was free of significant medication error when order for Depakene (medication used to treat seizures and challenging behaviors) was not transcribed into the electronic medical record (EMR) according to the physician's orders. This resulted in actual harm for R129, who didn't receive the medication for 63 days, had increased agitation, and fell sustaining a laceration requiring emergency care. Findings include:	21545	Continued From pa	age 28	21545			
During an observation on 10/15/18, at 6:28 p.m. R129 was observed in his room with a distressed look on his face, shaking and waving his hands, standing over his wife who was sitting in a wheelchair next to him. He stated, "her pants are too tight." The call light was on, but no staff were observed present in the hall. The surveyor alerted staff to R129's distress and an unidentified staff person attended to R129. R129's quarterly minimum data set (MDS) assessment dated 7/11/18, included a diagnosis of dementia. This quarterly MDS indicated R129 was unable to be interviewed because R129 was rarely/never understood. The MDS indicated R129 had long and short term memory deficits, exhibited inattentive behaviors including difficulty focusing attention, being easily distractible, and had difficulty keeping track of what was being said. According to the MDS, behavioral symptoms included both physical and verbal behaviors occurring during 1-3 days of the 7 day look back period.	21545	by: Based on observation review, the facility for residents (R129) refree of significant material Depakene (medical challenging behavious the electronic medical the physician's order harm for R129, who for 63 days, had inconsustaining a laceral Findings include: During an observation R129 was observed look on his face, should stand over his work wheelchair next to be too tight." The call observed present in alerted staff to R12 unidentified staff per R129's quarterly massessment dated of dementia. This quas unable to be in was rarely/never unable to be in was rarely/never unable to deficulty keeping said. According to the symptoms included behaviors occurring the significant of the significant	ion, interview, and document railed to ensure 1 of 5 eviewed for dementia care was nedication error when order for tion used to treat seizures and ors) was not transcribed into cal record (EMR) according to ers. This resulted in actual ordidn't receive the medication creased agitation, and fell tion requiring emergency care. Ition on 10/15/18, at 6:28 p.m. d in his room with a distressed taking and waving his hands, wife who was sitting in a him. He stated, "her pants are light was on, but no staff were in the hall. The surveyor 29's distress and an erson attended to R129. Inimum data set (MDS) 7/11/18, included a diagnosis puarterly MDS indicated R129 inderstood. The MDS indicated short term memory deficits, the behaviors including difficulty being easily distractible, and ing track of what was being the MDS, behavioral is both physical and verbal	21545		onding	

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Minnesota Department of Health STATE FORM

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

IDENTIFICATION NUMBER:

(X3) DATE SURVEY COMPLETED

B. WING 00979

A. BUILDING: ___

С 10/18/2018

		00979	B. WING		10/18/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
AUGUST	ANA HCC OF APPLE	VALLEY	RRETT AVE		
0/0.15	CHMMADV CTA		ALLEY, MN		1 0/5
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
21545	Continued From pa	ge 29	21545		
	A review of R129's following behavior	progress notes identified the documentation:			
	indicated R129 was R129 continued to here!". After lunch waiting for his wife her purse 'nearly per - Progress note daindicated R129 appaggressive with state Leave her alone! July 129 continued R129 appaggressive with state of the results of the	ed 6/13/18, at 2:23 p.m., as agitated during the morning. state, "the police should be R129 became frustrated and he aggressively grabbed alling her out of her seat." ted 6/21/18, at 11:02 a.m., beared agitated and verbally ff "What are you doing? ust get the hell out of here!". on his nightstand and made and to hit staff.			
	- Physician progres physician identified that were not easily some distress to se increase Depakene (milligrams) at bedi	is note on 7/3/18, the R129 as having behaviors redirectable, resulting in left and wife. The plan was to estrength from 250 mg time to 125 mg in the morning time for mood stabilization.			
	identified the follow had an order for Detreat challenging be at bedtime. On 7/3 from the physician Depakene to include morning, in addition order specified the be updated on R12 2 weeks. However, indicate an end dat the 7/17/18 doses,	Report dated 9/20/18, ing medication error: R129 epakene (a medication used to ehaviors) 250 mg (milligrams) /18, an order was received to increase the resident's le a 125 mg dose each in to the bedtime dose. The nurse practitioner (NP) was to 9's distress and behaviors in the order was transcribed to e in two weeks, and following the Depakene had been ddition, there was no indication			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE S COMPLI	
			A. BUILDING:			
		00979	B. WING		10/18	3/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VALLEY	RRETT AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21545	Continued From pa	ge 30	21545			
	regarding the impar had on R129's beh	n had ever received an update ct the additional Depakene aviors. ntinuation of the Depakene,				
	the nursing progres in behaviors:	ed 7/24/18, 2:03 p.m.,				
	indicated R129 pur causing medication	iched staff members arm is to spill on the floor as the ife. R129 stated, "leave her				
	indicated R129 bed receiving cares.	ed 8/3/18, at 9:54 p.m., came agitated while wife was				
	identified R129 as a	ed 8/5/18, at 1:39 p.m., agitated, pulling the dressings using to allow the nurse to				
	- Progress note dat indicated R129 did	ed 8/17/18, at 6:54 a.m., not sleep, using call light most o prevent care givers from				
	entering his side of - Progress note dat was holding wife, p	the room and hitting staff. ed 8/19/18 at 1:09 a.m., R129 reventing care givers from				
	swearing at staff Progress note dat	ng and biting staff. R129 was ed 8/20/18, at 2:25 p.m.,				
	breakfast, R129 co yelled, "they stole a protective over wife stated R129 was po floor in his room.	not go to dining room for nstantly pressing call light, all our stuff."; combative and b. Nursing assistant (NA) counding his wheelchair on the				
	R129 difficult to red wall and push assis does not have pant	ed 8/22/2018, at 6:21 a.m., lirect, continues to pound on st light. R129 angry that wife s on. Multiple attempts to help inues to swing walker at staff,				

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LE LED
		00979	B. WING		10/1) 8/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
		14650 GA	RRETT AVEI			
AUGUS1	ANA HCC OF APPLE	VALLEY	LLEY, MN			
(X4) I D	SUMMARY STA	TEMENT OF DEFICIENCIES	I D	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
21545	Continued From pa	ge 31	21545			
21545	charge at staff. - Progress note dat displayed 'major be wall, yelling, hitting when staff tried to a late for breakfast. F. - Progress note dat refused dressing charced dressing charced dressing charced did not want staff to wanting the police of still up trying to help. - Progress note dat on call light all night. - Progress note dat 129 refused bath. - Progress note dat pressing call light noffered, bang on the door waiting for her chair. - Progress note dat stated R129 trying 2 person/standing I NAs approached to agitated, grabbed swould not let go. National R129 still angry, paemergency call light police are on their v. - The Nurse Practit dated 9/11/18, lister not include Depake plan NP indicated a behavioral and psydementia (BPSD) thearing impairment	ed 9/4/1,8 at 11:23 a.m., R129 chaviors' today; pounding on several staff, aggressive assist wife. They were an hour Refused medications. Led 9/5/18 at 2:25 p.m., R129 change to his legs. Led 9/7/18, at 1:44 a.m., 129 chelp wife, kicking them out, called. Calmed down a little, owife. Led 9/7/18, at 6:28 a.m., R129 t. Led 9/8/18, at 5:27 p.m., R Led 9/8/18, at 5:27 p.m., R Led 9/10/18 2:18 p.m., R129 chelp. Trying to get wife out of Led 9/11/18, 10:25 p.m., NA Led 9/11/18, 1	21545			
	plan NP indicated a behavioral and psy dementia (BPSD) thearing impairment continue mood state	a diagnosis of dementia with chological symptoms of that "staff approach in light of matters. Certainly, also				

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PRINTED: 11/26/2018 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ \mathbf{C} B. WING 00979 10/18/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **14650 GARRETT AVENUE AUGUSTANA HCC OF APPLE VALLEY** APPLE VALLEY, MN 55124 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21545 Continued From page 32 21545 indicated the NA was present with wife and R129. R129 became combative when NA was attempting to provide care to wife. R129 began to try to hit and push NA and lost balance, body weight pushed back and he went backwards, hitting his head on the floor. Contusion noted with bleeding on the back of the head. R129 sent to the emergency room and received three staples to close the wound. The medication error with the Depakene was discovered on 9/20/18, by registered nurse (RN)-C while investigating R129's fall. The evaluation portion of the Medication Error Report dated 9/20/18, indicated an increase in R129's behaviors since the time of the discontinuation. During an interview on 10/17/18, at 10:53 a.m. with nursing assistant (NA)-H, NA-H verified R129 was very agitated at the time of the fall. NA-H stated he had turned his back on R129 because the resident was coming at him and NA-H knew if he turned, R129 would only hit his back. NA-H said he'd then heard a noise and when he turned around he saw R129 on the floor. NA-H further explained R129 was agitated because "I was trying to help his wife and he does not understand we are helping her even if we try to explain." During interview on 10/17/18 at 2:02 p.m.,

Minnesota Department of Health

registered nurse (RN)-C verified R129 had not received his Depakene for 63 days due to the order having been incorrectly entered into the EMR. RN-C stated the NP had identified the medication error while in the facility on 9/18/18. and had reinstated the medication. RN-C stated R129 had his first dose of Depakene again on 9/19/18 at 8:00 a.m., RN-C further explained that

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00979	B. WING		10/1	; 8/2018
					10/1	0/2010
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VALLEY	RRETT AVE ALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
21545	Continued From pa	ge 33	21545			
	retrospect she show the nurse received	ribing nurse stated in uld have clarified the order, education. However, the checked the order transcription rther education.				
	Efforts to interview	the NP were unsuccessful.				
	with the interim dire acknowledged she aware of the medic present in the facilit verified the medical recognized sooner	on 10/18/2018, at 11:39 a.m., ector of nursing (IDON), she had only recently became ation error as she was not ty during the occurrence. She tion error should have been and the physician should regarding R129's increase in				
	policy indicated the will review order do	18, Transcription of Orders nurse that verifies the order cumentation and ensure a full ers has been signed and is				
	administrator, direct consulting pharmac policies and proced of medication order errors. The DON or pharmacist, could a	THOD OF CORRECTION: The tor of nursing (DON) and cist could review and revise dures for proper transcription as to prevent medication designee, along with the audit transcription of on a regular basis to ensure				
	TIMEFRAME FOR (21) days.	CORRECTION: Twenty-one				
21550	MN Rule 4658.1329 Medications; Pharm	5 Subp. 1 Adminiatration of nacy Serv.	21550			11/29/18

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STATE FORM TEQW11 If continuation sheet 34 of 54

PRINTED: 11/26/2018 FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING 00979 10/18/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **14650 GARRETT AVENUE AUGUSTANA HCC OF APPLE VALLEY** APPLE VALLEY, MN 55124 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21550 Continued From page 34 21550 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This MN Requirement is not met as evidenced Based on interview and document review, the See plan of correction for corresponding facility failed to ensure medications were Federal tag. available and administered as prescribed by the physician for 1 of 1 resident (R448) with complaints of eye drop medication being unavailable. Findings include: R448's face sheet printed on 10/17/18, indicated R448 was admitted to the facility on 10/1/18. The face sheet identified R448 had a diagnosis of dry eye syndrome of unspecified lacrimal gland. During an initial interview on 10/15/18, at 1:10 p.m. R448 stated she had not gotten her prescribed eye drops since admission. R488 further stated she did not produce tears and indicated her eves had gotten blurry from not having the eye drops. Furthermore, R448 indicated she had asked a nurse why she hadn't received her eye drops and was told the eve

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drops were on back order with the pharmacy.

On 10/15/18, at 1:29 p.m. R448's physician orders were reviewed and included polycinyl alcohol (eye moistening agent) one drop to be administered to both eyes, three times daily for a diagnosis of dry eye syndrome of lacrimal gland. R448's orders also included Refresh classic (eye

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER:

Output

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

C

C

B. WING

10/18/2018

	00979			10/18/2018
NAME OF PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE	
AUGUSTANA HCC OF APPLE	VALLEY	ARRETT AVE ALLEY, MN		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
times daily as need lacrimal gland. R4-acetaminophen, Bifluvoxamine, Geod Prozac, Seroquel at On 10/15/18, at 1:3 administration reconstructed R448's powere "Drug/ Item uperiod of 10/4/18 at (10/15/18) which implement of 10/4/18 at (10/15/18) at (1	two drops to both eyes, four ded for dry eye syndrome of 48's allergies included enadryl, bupropion, don, ibuprofen, penicillin, and Vistaril. 32 p.m. R448's medication ord (MAR) was reviewed and olyvinyl alcohol eye drops inavailable" during the time at 6:00 p.m. to current included an 8:00 a.m., 12:00 administration times. R448's fied the "as needed" Refresh not been administered. In 10/16/18, at 1:29 p.m. hurse (LPN)-C indicated that of why R448's polyvinyl alcohol the facility and stated she tact the pharmacy. At 1:35 led the facility pharmacy vinyl alcohol drops were on a order for eye drops needed to C indicated she left a voice er to obtain an order for a pand was awaiting a return one of the facility pharmacy want to change to different elacked evidence that R448's			

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Minnesota Department of Health

AND DUAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					С	
		00979	B. WING		10/1	8/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
ALIGHET	ANA HCC OF APPLE	VALLEY 14650 GAI	RRETT AVE	NUE		
A00031	ANATICO OI AFFEL	APPLE VA	LLEY, MN	55124		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21550	Continued From pa	ge 36	21550			
	Refresh eye drops. shift and have prov-The note dated 10 made after surveyor facility staff) indica available and per pthey don't know wh Left v/m [voice mespractitioner] to check different medication refresh that helps with the properties of the puring interview on the province of the	10/17/18, at 11:34 a.m.				
	LPN-D stated she hadrops from the as na LPN-D further state pharmacy to see water were not at the faci indicated the provide polyvinyl eye drop of unavailable at the further indicated the	nad given R448's Refresh eye needed list in the morning. It is she would need to call the hy the polyvinyl eye drops lity. At 12:27 p.m. LPN-D liter needed to change R448's porder as these were acility pharmacy. LPN-D to provider had changed to de drop order to Refresh eye				
	a.m. the facility phathat if the pharmacy available, the pharm upon receipt of the pharmacy consultathen be expected to wait for the medical pharmacy for deliverather order an alter pharmacy consultation.	interview on 10/18/18, at 9:56 armacy consultant indicated y did not have a medication macy would notify the facility order through a fax. The nt stated the facility would be see if the provider wanted to tion to come into the ery or if the provider would rnative medication. The nt identified that once the ayed to the facility that the				

Minnesota Department of Health

STATE FORM TEQW11 If continuation sheet 37 of 54

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			С	
		00979	B. WING			8/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VALLEY	RRETT AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21550	medication was una facility to follow-up when the medication and/or ask the provide alternative medication following day, that is contact the provide alternative medications. The facility policy M 8/20/18, indicated "medications, contact the provide alternative medications, contact the provide alternative medications indicated "medications, contact the provide alternative medications, contact the provide alternative medications alternative medications timely, develop monitoring compliance and repassurance committing recommendations.	available, it would be up to the and continue to check-in on would become available rider to order an alternative. You on 10/18/18, at 10:29 a.m. ing (DON) stated that if the ion was unavailable by the t was her expectation to r and obtain an order for an ion. Medication Management dated to. If unable to obtain ct the resident's physician." THODS OF CORRECTION: sing (DON) or designee could and for revise policies and the facility orders The DON or designee could systems to ensure ongoing port the results to the quality	21550			
21565	, , ,	5 Subp. 4 Administration of dmin	21565			11/29/18
	self-administer med resident assessme care as required in 4658.0405 indicate	dinistration. A resident may dications if the comprehensive nt and comprehensive plan of parts 4658.0400 and this practice is safe and there om the attending physician.				

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10/18/2018

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING:

A BUILDING:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

C

(X3) DATE SURVEY
COMPLETED

C

00979 B. WING _____

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

	APPLE VA	· ,		
(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) COMPLET DATE
21565	Continued From page 38	21565		
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure supervision of resident unable to self-administer medications (SAM) for 1 of 1 resident (R447) observed to self-administer a nebulizer (inhalant medication).		See plan of correction for corresponding Federal tag.	
	Findings include:			
	On 10/15/18, at 12:57 p.m. R447 was observed in her room with a face mask on receiving a nebulizer (neb) treatment. There was no staff present in the room and/ or down the hallway. The registered nurse (RN)-E was observed seated in the nurse office and was not in the position to observe R447. At 1:06 p.m. RN-E was observed to enter R447's room, turned off the neb machine and removed R447's face mask.			
	R447's progress notes were reviewed; a note dated 10/16/18, indicated R447 was cognitively intact.			
	R447's physician order report dated 10/17/18, included: DuoNeb Solution for nebulization every six hours as needed for asthma with exacerbation.			
	R447's care plan dated 10/17/18, did not indicate R447's medication administration interventions.			
	R447's self-administration of medication (SAM) observation dated 10/14/18, concluded that R447 did not wish to exercise her right to self-administer medications.			
	During an interview on 10/15/18, at 2:35 p.m. RN-E stated that you know when a resident was			

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Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: __

(X3) DATE SURVEY COMPLETED С

		00979	B. WING		10/18/2018
	PROVIDER OR SUPPLIER TANA HCC OF APPLE	VALLEY 14650 GA	DRESS, CITY, S RRETT AVE ALLEY, MN		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
21565	teaching had been observed. RN-E ind documented in the self-administration would also be compouring an interview RN-F, unit nurse mot have an order for RN-F further review and verified that R4 indicated R447 was medications. On 10/18/18, at 10: (DON) stated it was observation be compounded by the c	ster medications after the done and the resident was dicated the teaching would be nurse progress notes and a of medication consent form pleted. You on 10/15/18, at 3:44 p.m. anager, indicated R447 did or SAM of neb treatment. Wed R447's SAM observation and able to self-administer 33 a.m. the director of nursing the expectation that a SAM in the pleted for all residents. The sted that if the resident was SAM it would be her see would remain present all medication. Self Administration of 7/25/18, included: "3. If the self-administer medications, cable observation/ assessment The policy further noted "12. reatment is set up for the sident is left alone with the that is considered of medications and the above	21565		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			COMPLETED	
		00979	B. WING		10/1	8/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AUGUST	ANA HCC OF APPLE	VALLEY	RRETT AVE			
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21565	Continued From pa	ge 40	21565			
	systems to ensure of report the results to	ee could develop monitoring ongoing compliance and the quality assurance er recommendations.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21620	MN Rule 4658.134	5 Labeling of Drugs	21620			11/29/18
	Drugs used in the n in accordance with	oursing home must be labeled part 6800.6300.				
	by: Based on observation review, the facility for opened and discard This had the potential.	on, interview and document ailed to date eye drops when deye drops when expired. ial to affect 2 of 9 residents a drops on the third floor.		See plan of correction for correspondent tag.	onding	
	Findings include:					
	medication carts on were two bottles of fumarate eye drops hand an open date drops (used to treat had an open date of had Rhopressa eye	15 p.m. a review of two third floor with RN-A. There eye drops for R128, Ketotifen (used to relieve itchy eyes) of 8/28 and Durezol eye eye pain and inflammation) of 8/20. The other resident, R7, edrops (used to lowers eye indicate when the bottle was				
	(RN)-A verified Keto drops should not be	15 p.m. registered nurse otifen fumarate and Durezol e use after being open for 28 Rhopressa did not have an				

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PRINTED: 11/26/2018 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ \mathbf{C} B. WING 00979 10/18/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE **AUGUSTANA HCC OF APPLE VALLEY** APPLE VALLEY, MN 55124 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21620 Continued From page 41 21620 open date written on it. RN-A further stated she did not know how facility staff would justify when the eye drops would be expired if there were not an open date written on the medications. RN-A explained there were no eye drop medication expiration directions on the medication carts. There should have been a "cheat-sheet" on each medication-passing cart which would indicate the duration various medications could be used. R128's physician orders dated 6/26/2018, included Durezol drops 0.05% solution one drop ophthalmic twice a day and Ketotifen Fumarate drops solution (0.025% (0.035%) one drop ophthalmic twice a day. A review of R128's medical administration record (MAR) indicated R128 had been receiving the drops daily. R7's physician orders dated 10/9/2018, included Rhopressa 0.02% solution one drop in both eyes at bedtime. A review of R7's MAR indicated R7 been receiving the drops daily. On 10/17/18, at 1245 p.m. the pharmacist stated the facility staff should have placed an open date on the eye drops when the eye drops were put in use. The pharmacist verified the Center of Medicare and Medicaid Services (CMS) regulation directed facility staff to discard eye drops after 28 days of being open unless manufacturer's instructions allowed for a longer

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time period.

On 10/18/2018, at 0845 a.m. RN-B confirmed eye medications should have a hand written open date on the medication container when put into use and staff should discard any eye drop medications 28 days after the open date unless

the manufacturer directed otherwise.

PRINTED: 11/26/2018 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING 00979 10/18/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE **AUGUSTANA HCC OF APPLE VALLEY** APPLE VALLEY, MN 55124 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21620 Continued From page 42 21620 On 10/18/18, at 10:05 a.m. the director of nursing (DON) confirmed her expectation would be for staff to write an open date on eye medication when put in use. The DON confirmed the eye drops should be used for 28 days unless the manufacturer instructed otherwise. DON confirmed R7's sample box of Rhopressa 0.02% did not have an open date written on it. On 10/18/18, at 1:19 p.m. DON stated Ketotifen fumarate drops 0.025% (0.035%), Durezol drops, and Rhopressa 0.02% should be discarded 28 days after opening. Review of the facility "Eye medication"/"Medication management" policy dated 7/5/2018, did not indicate directions related to open dates and discard dates for eye drops. Review of the facility "Medication Storage" policy dated 7/25/18, indicated "the facility shall not use discontinued, outdated or deteriorated drugs or biologicals". SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and

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compliance.

(21) days.

consulting pharmacist could review and revise policies and procedures for labeling and

disposition 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 on a regular basis to ensure

TIME PERIOD FOR CORRECTION: Twenty-one

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PRINTED: 11/26/2018 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING 00979 10/18/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE **AUGUSTANA HCC OF APPLE VALLEY** APPLE VALLEY, MN 55124 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21810 MN St. Statute 144.651 Subd. 6 Patients & 11/29/18 Residents of HC Fac. Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document See plan of correction for corresponding review, the facility failed to ensure the call light Federal tag. was within reach for 1 of 2 residents (R30). Findings include: During observation on 10/15/18 at 3:00 p.m. R30 was sitting up in her wheelchair next to her bed. When interviewed R30 stated she did not know where her call light was located. R30 also stated she did not know where her call light was most of

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the time. The call light was noted wrapped around the large oxygen tank away from her bed, which was behind R30 and with the bedside table in between the tank and the bed. Resident also stated there were times she needed help with assistance to go to the bathroom or use bedpan. but was not able to call for help because the call light was not placed within reach. On 10/15/18 at 3:39 p.m. Licensed Practical Nurse (LPN-A) was notified of R30 needing assistance. At 3:44 p.m. LPN-A entered the room and told R30 "It looks like you didn't get your call light", LPN-A verified

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PRINTED: 11/26/2018 FORM APPROVED Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ С B. WING 00979 10/18/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE **AUGUSTANA HCC OF APPLE VALLEY** APPLE VALLEY, MN 55124 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21810 Continued From page 44 21810 the call light was not within reach, moved the call light and handed it to R30. R30's Face sheet dated 8/2/18 indicated R30 had diagnoses including generalized muscle weakness. R30's Care plan dated 7/16/18 identified R30 was non ambulatory; required assist with toileting, mobility, activities of daily living. R30 was alert and oriented, R30 needed to have "call light within reach". R30's Care Area Assessment 8/2/18 indicated R30 was at risk for falls, required assist with ADL's and staff to assure call light was within reach at all times while in room. On 10/18/18 at 1:18 p.m. the registered nurse (RN-C) also nurse manager was interviewed and stated residents call lights were expected to be placed within reach "at all times". The facility's call light response policy dated 3/17, indicated call lights were to be placed so it would be accessible to the resident at all times, the call light should be secured to stay within the access of the resident. SUGGESTED METHOD OF CORRECTION:

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The director of nursing (DON) or designee, could develop and implement policies and procedures related to the call lights. The DON or designee, could provide training for all nursing staff related to call lights. The quality assessment and assurance committee could perform random

TIME PERIOD FOR CORRECTION: Twenty-one

audits to ensure compliance.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		A. BUILDING:	<u> </u>	JOHN LETEB		
00979		B. WING		10/1	C 1 <mark>8/2018</mark>	
NAME OF I	PROV I DER OR SUPPL I ER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		14650 GA	RRETT AVE	NUE		
AUGUST	ANA HCC OF APPLE	VALLEY	ALLEY, MN			
(X4) I D	SUMMARY STA	TEMENT OF DEFICIENCIES	I D	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX	,	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
TAG	REGOLATORY ON E	OO IDENTII TINO INI ORMATION)	TAG	DEFICIENCY)	TIMATE	
21810	Continued From pa	ae 45	21810			
	1					
	(21) days.					
21830	MN St. Statute 144	.651 Subd. 10 Patients &	21830			11/29/18
2.000	Residents of HC Fa					11/20/10
	0 1 1 10 5 11 1					
	notification of family	pation in planning treatment;				
		y members.				
	(a) Residents shall	II have the right to participate				
	in the planning of th	neir health care. This right				
		unity to discuss treatment and				
		dividual caregivers, the				
		est and participate in formal				
		and the right to include a				
		ther chosen representative or that the resident cannot be				
		ember or other representative				
		lent may be included in such				
	conferences.	ioni may be meladed in each				
		vho enters a facility is				
		natose or is unable to				
	communicate, the f	acility shall make reasonable				
		under paragraph (c) to notify				
	_	nber or a person designated in				
	, ,	ent as the person to contact in				
		the resident has been				
		lity. The facility shall allow the				
		articipate in treatment				
		e facility knows or has reason ent has an effective advance				
		trary or knows the resident				
		ting that they do not want a				
	•	uded in treatment planning.				
		nily member but prior to				
		ember to participate in				
		the facility must make				
		consistent with reasonable				
		determine if the resident has				
	executed an advan	ce directive relative to the				

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AND PLAN OF CORRECTION IN IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00979	B. WING		10/18	; 8/2018
	PROVIDER OR SUPPLIER	VALLEY 14650 GA	DRESS, CITY, S ARRETT AVEI ALLEY, MN 4			
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21830	esident's health car this paragraph, "rea (1) examining the resident; (2) examining the resident in the poss (3) inquiring of a family member con whether the resident directive and whether the resident normally gwhether the resident normally gwhether the resident designated emergemember to participa accordance with the liable to resident for that the notification emergency contact family member was patient's privacy rig (c) In making rea family member or dontact, the facility members or a designate examining the persand the medical reconsession of the facility and the medical reconsession, the facility has been member or designated.	re decisions. For purposes of asonable efforts" include: e personal effects of the emedical records of the session of the facility; my emergency contact or tacted under this section at has executed an advance her the resident has a the resident normally goes for the physician to whom the loes for care, if known, at has executed an advance y notifies a family member or ency contact or allows a family ate in treatment planning in a paragraph, the facility is not redamages on the grounds of the family member or or the participation of the simproper or violated the	21830			

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PRINTED: 11/26/2018 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ \mathbf{C} B. WING 00979 10/18/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE **AUGUSTANA HCC OF APPLE VALLEY** APPLE VALLEY, MN 55124 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21830 Continued From page 47 21830 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. This MN Requirement is not met as evidenced See plan of correction for corresponding Based on observation, interview and document review, the facility failed to honor 1 of 6 residents Federal tag. (R114) preferences for hours of sleep and toileting choices who were reviewed for self-determination. Findings include: During an interview on 10/15/18, at 4:39 p.m., R114 stated although she preferred to go to bed at 10:00 p.m., most evenings staff assisted her to bed starting as early as 8:00 p.m. R114 explained she watched television programs during this time. R114 also stated that she took a three-hour nap after lunch and was not normally tired before

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10 p.m.. She enjoyed working on her computer in the in the evening. R114 felt "rushed to go to bed" because staff were sometimes scheduled for a shortened shift. R114 said when staff were scheduled to leave early they encouraged her to do oral care, wash up and put her night gown on around 8:00 p.m., When this happened, R114 either sat in her wheelchair for two hours or went into bed as early as 8:00 p.m. to watch TV, R114

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			2			
		00979)	B. WING			୦ 1 <mark>8/2018</mark>	
NAME OF PROVIDER OR	SUPPLIER		STREETAD	DRESS, CITY, S	STATE, ZIP CODE			
AUGUSTANA HCC O	F APPLE	VALLEY		RRETT AVE ALLEY, MN				
PREFIX (EACH D	EFICIENC'			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
bowel moven courage brief. R114 use the be and and to "That was incontinent take time to she was al "normal" for pad. She from and not go During an nursing as ended at 1 preferred to explained a she talked her preferred to explained a she talked her preferred to 10:00 p.m. On 10/16/2 again and bed early (put her nig wheelchair her TV pro aware of indocuments. On 10/16/2 said she exall residents shortened.	I she wan rements, d her to said the dpan, she dpan, she dpan in the following of allowing the form of the following the form of the following the form of the following the form of the f	nted to use however, s defecate in e last time s he was told shat if she was ake." R114 el and felt sther to use the bed. R114 have a bow ker skin. Yon 10/16/1 NA)-F states of until 10:00 evenings she bout going to me and "soother explained uld get "late and uld get "late and she did not want R114 explained she careplan. 7 p.m., a registraft to follon staff was see expected and the care of the car	her incontinent he requested to she had a pad on anted. R114 stated, stated she was not aff did not want to be bedpan unless also said it was el movement in her as uncomfortable. 8, at 3:15 p.m., the did her shift usually a saware R114 p.m. and a cared for R114, to bed earlier than metimes she did ed she was not if she stayed past points." 14 was interviewed on and did not want to go to and did not want to com. and sit in her staff to interrupt ained staff was	21830				

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PRINTED: 11/26/2018 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ \mathbf{C} B. WING 00979 10/18/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE **AUGUSTANA HCC OF APPLE VALLEY** APPLE VALLEY, MN 55124 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21830 Continued From page 49 21830 RN-B further was aware of R114's choice for hours of sleep but was not aware this was not consistently honored, RN-B further stated R114 should be allowed to use the toileting method she preferred and that staff should follow the care plan and honor R114's choices. On 10/16/18 at 3:58 p.m., a nursing assistant NA-F stated when R114 was in bed she would be put on the bedpan otherwise she "used her pad". On 10/17/18, at 12:29 p.m. NA-B stated either R114 "goes in her pad"or was asked to be put on the bedpan. He further explained when she used the bed pan remained continent of bowel. The Urinary Incontinence and Indwelling Care Assessment Area Analysis of Findings, dated 1/15/18, indicated R114 was frequently incontinent of bowel related to mobility and recent issues with loose stools. Staff was to offer assistance with toileting every two hours and to provide incontinent products and peri care two times a day and as needed. A Foley catheter was in place related to urinary incontinence. The Minimum Data Set (MDS) Preferences for Customary Routine and Activities, dated 1/15/18. indicated it was "very important" for R114 to choose her own bed time. The MDS further noted

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R114 was frequently incontinent of bowel and was assisted with toileting needs. The MDS(s) Dated 1/15/18, 7/2/18, and 9/25/18 indicated R114 had no memory loss or acute changes in

The Augustana Care Health and Group Sheet dated 10/2/18, noted R114's bedtime was 10:00 p.m. and indicated R114 was incontinent of

mental status and R114 had intact.

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AND DIAN OF CODDECTION INDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00979	B. WING		10/1	8/2018
	PROVIDER OR SUPPLIER	VALLEY 14650 GA	DRESS, CITY, S RRETT AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21830	bowel and required further direction regchoices were address. R114's Care Plan regretered to gpreferred not to get 10:00 p.m., and diregan for bowel move it. During an interview Interim Director of National Cares and assistant provided as their caresidents residents possible. The Augustana Care Dignity, Choices and 4/16 indicated: It is residents will be treat all times. The far place to honor residenterences per plate accommodation. Repreferences will be at quarterly care cowill be care planned choices and preferences and preferences will be discussed when fits review will documented if need encouraged to voice.	assistance of two staff. No garding toileting needs or essed. evised 10/2/18, indicated to to bed at 10:00 p.m. She ready for bed earlier than ected staff not to use the bed ements unless she asked for on 10/18/18, at 1:10 p.m., the Nursing, stated she expected be for all residents would be are plan indicated and as preferred/chose, when the standard of care that all eated with respect and dignity cility will also put protocols in dent's choices and an of care and reasonable esident's choices and reviewed upon admission and enferences. These preferences dias appropriate. Resident's ences that could affect their ead to unsafe/poor outcomes ith the resident and a risk to be completed and ded. Residents will be e their concerns and needs at their needs, choices and	21830			

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AND DIAN OF CODDECTION INDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED	
		00979	B. WING		10/1	8/2018
	PROVIDER OR SUPPLIER	VALLEY 14650 GA	DRESS, CITY, S RRETT AVE		-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21830	SUGGESTED MET The director of nurs develop policies an has a system to kno dislikes, including of daily living and daily	THOD OF CORRECTION: sing (DON) or designee could d procedures to ensure facility ow residents' likes and choices regarding activities of	21830			
21840	Residents of HC Fa Subd. 12. Right to residents shall have based on the inform 9. Residents who re or dietary restriction likely medical or mather refusal, with do- medical record. In control, incapable of unders but has not been as when legal requirer treatment, the control	ac.Bill of Rights orefuse care. Competent enter right to refuse treatment mation required in subdivision refuse treatment, medication, as shall be informed of the ajor psychological results of cumentation in the individual cases where a resident is estanding the circumstances djudicated incompetent, or ments limit the right to refuse litions and circumstances nented by the attending ident's medical record.	21840			11/29/18
	by: Based on interview facility failed to ens emergency care an reflected in all area records to ensure r implemented correc	and document review, the ure advanced directives for d treatment were accurately s of the residents medical esidents wishes would be ctly in an emergency situation (R58) reviewed for advanced		See plan of correction for corresp Federal tag.	onding	

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PRINTED: 11/26/2018 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING 00979 10/18/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14650 GARRETT AVENUE **AUGUSTANA HCC OF APPLE VALLEY** APPLE VALLEY, MN 55124 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21840 Continued From page 52 21840 Findings include: R58's Provider Orders for Life Sustaining Treatment (POLST) dated 3/1/16, indicated R58's wishes of "DNR [do not resuscitate]/ DO NOT ATTEMPT RESUSCITATION (Allow Natural Death)", and goals of treatment, were identified as "COMFORT CARE". The document was signed by the physician and R58's mother. The undated Resident Face Sheet indicated the resident's Advanced Directives (a health care decision made in the event that one becomes unable to make those decisions) was "Full Code" and indicated to review the POLST dated 3/1/16. R58's current Physicians Order Report dated signed 8/3/18, had an order with a start date 5/21/2014, and end date 8/2/2018, indicated R58's "Code Status: DNI/DNI [do not intubate] comfort cares see POLST". There was also a note indicating "Awaiting DC [discontinuation] Verification (DC Date 8/2/18)'. There was another order open ended order with start date 8/2/18, noting "Code Status: Full Code", also indicating "Awaiting Verification". A third open ended order from 8/14/18, also indicated "Code Status: Full Code- CLARIFY".

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and clarified.

There was no evidence in R58's medical record

that discrepancies between the POLST, facesheet and physician's orders were verified

On 10/16/18, at 9:23 a.m. registered Nurse (RN)-B confirmed R58's code status in the

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(14) days.

staff related to advance directives. The quality assessment and assurance committee could perform random audits to ensure compliance.

TIME PERIOD FOR CORRECTION: Fourteen

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