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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TEQW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00979

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245264**

2.STATE VENDOR OR MEDICAID NO.
(L2) **176622800**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA HCC OF APPLE VALLEY**
(L4) **14650 GARRETT AVENUE**
(L5) **APPLE VALLEY, MN** (L6) **55124**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/25/2006**

6. DATE OF SURVEY **12/19/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **178** (L18)
13.Total Certified Beds **178** (L17)

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	178			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Eva Loch, Unit Supervisor 01/07/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 01/08/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1983
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/03/2018
(L33)

DETERMINATION APPROVAL

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.

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
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 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,

Douglas Larson, Enforcement Specialist

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: TEQW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00979

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(L1) **245264**
2.STATE VENDOR OR MEDICAID NO.
(L2) **176622800**

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(L3) **AUGUSTANA HCC OF APPLE VALLEY**
(L4) **14650 GARRETT AVENUE**
(L5) **APPLE VALLEY, MN** (L6) **55124**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/25/2006**
6. DATE OF SURVEY **10/18/2018** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **178** (L18)
13.Total Certified Beds **178** (L17)

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___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	178			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date:
Jodie Fox, HFE NE II — 11/19/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Douglas Larson, Enforcement Specialist — 11/30/2018 (L20)

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

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

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1983
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
November 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 10/15/18 through 10/18/2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 10/15/18 through 10/18/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An investigation of complaint's H5264074 and H5264075 were completed. The complaints were substantiated and deficiencies were cited at F744 and F760.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)	F 554		11/29/18

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

Electronically Signed | 11/12/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 1 §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure supervision of resident unable to self-administer medications (SAM) for 1 of 1 resident (R447) observed to self-administer a nebulizer (inhalant medication). 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	F 554	Immediate Plan of Correction: Identified nurse was individually re-educated to facility policy on self-administration of medications. R447 was discharged on 11/3/18. Identification of Other Residents: All residents with nebulizer orders have been reviewed to see if they are appropriate to self-administer their nebulizer. Additionally, we reviewed to determine if other medications were being self-administered without an assessment or order. If they were, a self-administration of medication observation has been completed and we have obtained orders from the provider as indicated. Care plans for those residents self-administering medications have been updated to reflect ability to self-administer medications. Measures Put in Place: Education will be completed with licensed staff regarding the self-administration of medication policy. Monitoring Mechanisms: Audits will be completed of 5 residents per week X 3 months to assure appropriate self- administration of medication observation, orders and care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245264	A. BUILDING _____ B. WING _____	C 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

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F 554	Continued From page 2 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 able to self-administer medications after the teaching had been done and the resident was observed. RN-E indicated the teaching would be documented in the nurse progress notes and a self-administration of medication consent form would also be completed. During an interview on 10/15/18, at 3:44 p.m. RN-F, unit nurse manager, indicated R447 did not have an order for SAM of neb treatment. RN-F further reviewed R447's SAM observation and verified that R447's SAM observation indicated R447 was not able to self-administer medications. On 10/18/18, at 10:33 a.m. the director of nursing (DON) stated it was her expectation that a SAM observation be completed for all residents. The DON further indicated that if the resident was deemed unable to SAM it would be her expectation the nurse would remain present while administering all medication. The facility policy Self Administration of Medications dated 7/25/18, included: "3. If the resident wishes to self-administer medications, complete the applicable observation/ assessment form in the EHR. " The policy further noted "12. When a nebulizer treatment is set up for the resident and the resident is left alone with the treatment running, that is considered self-administration of medications and the above steps will be followed."	F 554	plan are in place if resident is self-administering any medications. Results of audits will be reviewed by the facility□s QAPI committee and further audits will be recommended by them as indicated. Person responsible for compliance: Director of nursing or designee is responsible for compliance.	

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F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the call light 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 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 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	F 558	Immediate Plan of Correction: Call light was given to R30 on 10/15/18 when notified that call light was not in reach. Identification of Other Residents: Nursing leadership staff audited all residents to ensure call lights were in reach on 10/18/18. Measures Put in Place: Education completed with all staff regarding proper placement of call lights. Monitoring Mechanisms: Facility staff will audit 10 rooms per week X 3 months to ensure call lights are in reach. Results of audits will be reviewed by the facility□s QAPI committee and further audits will be recommended by them as indicated. Person responsible for compliance: Director of nursing is responsible for compliance.	11/29/18

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F 558	Continued From page 4 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.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her	F 561		11/29/18

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F 561	Continued From page 5 interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to honor 1 of 6 residents (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 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	F 561	Immediate plan of correction: NAR assignments were changed so that the NAR caring for R114 stays until 11pm which allows for time for R114 to stay up until 10pm per her preference. NAR assignment sheet was updated to have staff offer R114 the bedpan each shift. Identification of other residents: Facility staff interviewed all residents to ensure their preferences for toileting and bedtime are being honored. Measures put in place: Nursing staff were re-educated on the importance of asking residents about their preferences before providing cares and the importance of honoring those preferences.	

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F 561	Continued From page 6 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 also stated she wanted to use a bedpan for bowel movements, however, staff often encouraged her to defecate in her incontinent brief. R114 said the last time she requested to use the bedpan, she was told she had a pad on and and to go in that if she wanted. R114 stated, "That was hard to take." R114 stated she was not incontinent of bowel and felt staff did not want to take time to allow her to use the bedpan unless she was already in bed. R114 also said it was "normal" for her to have a bowel movement in her pad. She further explained it was uncomfortable and not good for her skin. During an interview on 10/16/18, at 3:15 p.m., the nursing assistant (NA)-F stated her shift usually ended at 10:00 p.m.. NA-F was aware R114 preferred to stay up until 10:00 p.m. and explained on the evenings she cared for R114, she talked to her about going to bed earlier than her preferred bedtime and "sometimes she did not mind." She further explained she was not allowed to work a full shift and if she stayed past 10:00 p.m. she would get "late points." On 10/16/18, at 3:40 p.m., R114 was interviewed again and explained she did not want to go to bed early (before 10:00 p.m.) and did not want to put her night gown on at 8:00 p.m. and sit in her wheelchair. R114 did not want staff to interrupt her TV programs. R114 explained staff was aware of her preferences because it was documented on her careplan.	F 561	Monitoring mechanisms: All residents are asked if their preferences are being met during care conferences. Random audits will be completed of 15 residents per month X 3 months to confirm that their preferences are being honored. Results of these audits will be reviewed by the facility's QAPI committee and additional audits will be recommended by them if indicated. Person responsible for compliance: Director of nursing is responsible for compliance.	

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F 561	Continued From page 7	F 561		

On 10/16/18 at 3:47 p.m., a registered RN-B said she expected staff to follow the care plan of all residents. When staff was scheduled for a shortened shift, she expected another staff to assist R114 to bed as her care plan indicated. 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 R114 was frequently incontinent of bowel and was assisted with toileting needs. The MDS(s)

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F 561	Continued From page 8	F 561		

Dated 1/15/18, 7/2/18, and 9/25/18 indicated R114 had no memory loss or acute changes in mental status and R114 had intact.

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 bowel and required assistance of two staff. No further direction regarding toileting needs or choices were addressed.

R114's Care Plan revised 10/2/18, indicated R114 preferred to go to bed at 10:00 p.m. She preferred not to get ready for bed earlier than 10:00 p.m., and directed staff not to use the bed pan for bowel movements unless she asked for it.

During an interview on 10/18/18, at 1:10 p.m., the Interim Director of Nursing, stated she expected cares and assistance for all residents would be provided as their care plan indicated and as residents residents preferred/chose, when possible.

The Augustana Care Policy: Observing Resident Dignity,Choices and Preferences, effective date 4/16 indicated: It is the standard of care that all residents will be treated with respect and dignity at all times. The facility will also put protocols in place to honor resident's choices and preferences per plan of care and reasonable accommodation. Resident's choices and preferences will be reviewed upon admission and at quarterly care conferences. These preferences will be care planned as appropriate. Resident's choices and preferences that could affect their care negatively or lead to unsafe/poor outcomes

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F 561	Continued From page 9 will be discussed with the resident and a risk to benefits review will be completed and documented if needed. Residents will be encouraged to voice their concerns and needs at all times to ensure their needs, choices and preferences are honored. All staff are responsible.	F 561		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by:	F 577		11/29/18

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F 577	Continued From page 10 Based on observation, interview and document review, the facility failed to post notice of availability of previous three years of State Agency survey results. This had the potential to affect all 161 residents residing in the facility, visitors and staff who wished to review this information. Findings include: On 10/18/18, at 9:26 a.m. the survey results dated 12/4/17, were observed in plastic holder next to the bulletin board across from the first floor elevator. No note regarding previous three years survey results location was observed on the holder or the bulletin board next to the holder. On 10/18/18, at 9:49 a.m. the Interim Director of nursing (IDON) verified no previous three years survey results or note of availability of previous three years survey results were on 1st floor. At 10:01 a.m. the 2nd floor was observed. The survey results dated 12/4/17, was posted across from the elevator. IDON verified only survey results were available for review, however there was no notice of availability of the previous three years of survey results. At 10:02 a.m. the 3rd floor was observed with IDON. IDON verified only previous years survey results were posted, and there was no sign indicating the availability of the previous three years survey results. IDON stated she had not been aware the previous three year survey results were to be made available to the residents and visitors. IDON verified no note of location of previous surveys on the bulletin board across from the elevator, or on the units. The facility Survey Results Posting policy dated	F 577	Immediate Plan of Correction: A sign was created and posted by the survey results explaining that the last 3 years of survey results are available at the receptionist desk. A 3-ring binder was created with the last 3 years of survey results, certifications, and complaint investigations and any plans of correction that are in place. This is available at the receptionist desk. Identification of Other Residents: No other residents involved. Measures Put in Place: A sign was created and posted by the survey results explaining that the last 3 years of survey results are available at the receptionist desk. A 3-ring binder was created with the last 3 years of survey results, certifications, and complaint investigations and any plans of correction that are in place. This is available at the receptionist desk. Monitoring Mechanisms: A designated facility staff will confirm once per month X 3 months that this sign and the 3-ring binder are still in place and is updated. Person responsible for compliance: Business office manager is responsible for compliance.	

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F 577	Continued From page 11 5/21/18, indicated the facility would post notice of availability of three preceding years of survey results in prominent and accessible areas of the facility to the public.	F 577		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;FormIte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		11/29/18

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F 578	Continued From page 12 individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure advanced directives for emergency care and treatment were accurately reflected in all areas of the residents medical records to ensure residents wishes would be implemented correctly in an emergency situation for 1 of 1 residents (R58) reviewed for advanced directives. 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	F 578	Immediate Plan of Correction: The POLST, MD order for code status and face sheet on R58 were updated immediately on October 16, 2018. Identification of Other Residents: An audit was completed on 11/12/18 to ensure that all code status orders, POLST and face sheets match. Measures Put in Place: Health information and nursing staff have been educated on the updated policy related to POLST form implementation which was revised and updated on 11/7/18. Health information staff have been re-educated on the importance of following up on orders that need to be clarified, so they are not left as open ended orders. Monitoring Mechanisms: A random sample of 20% of resident charts will be audited one time per month X 3 months to confirm that the code status order, POLST and face sheet information match related to code status. Results of the audits will be reviewed by	

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F 578	Continued From page 13 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". There was no evidence in R58's medical record that discrepancies between the POLST, facesheet and physician's orders were verified and clarified. On 10/16/18, at 9:23 a.m. registered Nurse (RN)-B confirmed R58's code status in the electronic medical record (EMR) did not match the code status in R58's POLST. RN-B explained social services should have given the POLST to a health unit coordinator (HUC) to update R58's code status in her chart. On 10/16/18, at 9:35 a.m. licensed practical nurse (LPN)-E shared she preferred looking in the paper chart for a resident's code status as it was more specific and the code status could also be found in the EMR. On 10/18/18, at 10:05 a.m. interim director of nursing (IDON) indicated she was made aware of the concern with R58's code status, and the POLST not matching the EMR. DON expressed the records updating process was not followed in R58's case.	F 578	the facility□s QAPI committee and they will make recommendations for further monitoring as indicated. Person responsible for compliance: Health information director is responsible for compliance.	

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F 578	Continued From page 14 The facility's Physician Order for Life Sustaining Treatment (POLST) policy dated 06/21/2018, indicated "8. Social Services or designee will document in the resident medical record if the resident has a Health Care Directive. This is also noted on the Face Sheet of the resident's electronic health record".	F 578		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide restorative services for 2 of 4 residents (R85, R114) reviewed for rehabilitation. Findings include:	F 688	Immediate Plan of Correction: Education was provided to staff that restorative programs need to be completed. If they are unable to complete the exercises or the resident refuses they are to notify the nurse.	11/29/18

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F 688	Continued From page 15 R85's quarterly Minimum Data Set (MDS) dated 9/11/18, indicated R85's cognition was intact, needed limited staff assistance to transfer and walking in room and corridor was marked as a"-" (meaning not assessed). R85's significant change MDS dated 6/18/18, indicated R85 needed limited staff assistance with transfers and walked in her room and in the corridor with staff supervision. R85's careplan dated 3/29/18, indicated nursing staff were to walk R85 in the hallway using walker two times daily to maintain gains made in physical therapy and R85 ambulated 15-30 feet. On 10/15/18, at 10:23 a.m. R85 told surveyor she was supposed to get walked two times a day but "almost always" was not walked in the mornings. R85 stated nursing assistant (NA)-C would tell her he was "too busy" to walk her. R85 stated she was "going down hill" from not being walked. R85 stated she was supposed to be walked down the hall as far as she could go twice a day and the distance kept track of. R85 stated she was also attending therapy for strengthening exercises. On 10/17/18, at 1:01 p.m. registered nurse (RN)-A stated R85 was on a restorative program for walking and also attended therapy. RN-A stated R85 was doing a lot better now since therapy had gotten R85 up and walking. Review of R85's Point of Care History for walking dated 9/1/18-10/18/18, indicated 25 x NAs documented "Not Performed", 46 x NAs documented "unanswered" and 24 x documented completed by NAs.	F 688	Identification of Other Residents: An audit of point of care charting related to restorative nursing programs was completed on 11/12/18 to identify any other residents where staff were either not documenting or not completing the restorative nursing program as ordered. Measures Put in Place: Policy on range of motion was revised on 11/7/18. Nursing staff were educated on the importance of completing restorative nursing programs as ordered. Monitoring Mechanisms: Clinical managers will audit completion of restorative nursing programs on all residents in the building twice per week X 4 weeks and then weekly X 4 weeks and then monthly X 2 months. Results of audits will be reviewed by the QAPI committee and further monitoring will be recommended by them as indicated. Person responsible for compliance: Director of nursing is responsible for compliance.	

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F 688	Continued From page 16 On 10/18/18, at 12:24 p.m. RN-B stated R85 had weakness in her legs, wanted to walk on her own, and could now walk short distances. RN-B looked at the Point of Care documentation on the computer from 10/10/18, through 10/18/18, and stated it looked like R85 was not being walked every morning. Based on data walking had only been completed three times (times), documented "Not Performed" five times, and documented "unanswered" ten times by the NAs. RN-B stated walking was a part of R85's rehabilitation program to be completed by the NAs twice a day and had been unaware R85 was not being walked every morning and/or afternoon. On 10/18/18, at 12:47 p.m. NA-G stated R85 had a walking program and would walk R85 in the morning as far as she could walk and document. NA-G stated R85 six months ago could not walk, had improved with therapy and had never refused to walk. NA-G stated R85 was able to walk in her room with her walker independently to and from the bathroom, but needed her wheelchair for further distances like to the dining room. On 10/18/18, at 1:31 p.m. NA-C stated R85 was on a walking program and could walk on some days 50 feet or more. NA-C stated he tried to walk R85 in the mornings but could not always do that when less than full staffed. NA-C stated he told the nurses when he could not walk R85 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	F 688		

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F 688	Continued From page 17 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 leg syndrome related to MS, hemiplegia, 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 intact. The Care Assessment Area (CAA) dated 1/15/18, did not include any information 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	F 688		

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F 688	Continued From page 18	F 688		

undated Resident Sheet (NA assignment sheet) 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.

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F 688	Continued From page 19 On 10/17/18 at 1:31 p.m. the director of therapy clarified R114 was seen by therapy twice each 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." 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 assistance.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		11/29/18

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F 689	Continued From page 20 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a comprehensive assessment, ongoing monitoring and evaluation for safe smoking was completed for 1 of 1 resident (R455) reviewed for smoking. 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 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 store his own cigarettes and lighter in his room.	F 689	Immediate Plan of Correction: R455 was transferred to the hospital on 10/15/18 and remained there through the duration of the survey. He returned from the hospital on 10/24/18 and a smoking risk assessment was completed at that time. He has since been discharged to home. Identification of Other Residents: There are no other residents in the building who smoke at this time. Measures Put in Place: Licensed nursing staff will be re-educated on the importance of completing a smoking risk assessment on any resident who is smoking, even if they are going off campus to smoke. Monitoring Mechanisms: Admissions staff will alert the administrator any time a resident who smokes or has recently smoked per the pre-admission screening. The administrator will prompt nursing staff to complete a smoking risk assessment if	

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F 689	Continued From page 21 On 10/15/18, at 3:23 p.m. R455 was observed outside on the facility property, inside the gazebo, in the middle of the facility driveway smoking a cigarette. R455 did not have any burns on his fingers and/or clothing and extinguished his cigarette onto the ground. During interview on 10/15/18, at 2:33 p.m. registered nurse (RN)-H stated there were not any residents who smoke residing on the unit. During an interview on 10/15/18, at 2:35 p.m. RN-E stated the facility was non-smoking and if a resident had cigarettes and/or a lighter, the facility would lock the items up until a smoking assessment was completed. R455's Cognitive Performance Test (CPT) dated 10/4/18, indicated intact cognition. R455's admission Care Area Assessment dated 10/5/18, lacked evidence of R455's nicotine dependence and tobacco use. R455's Minimum Data Set (MDS) dated 10/5/18, indicated R455's did not currently use tobacco. R455's care plan revised 10/16/18, identified R455 as a "smoker or history of smoking." However, the individualized care plan lacked evidence of interventions related to R455's smoking and/ or smoking history. 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 to smoke pt did x [times] 2." R455's medical record was reviewed on	F 689	the resident is smoking. Person responsible for compliance: Administrator is responsible for compliance.	

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10/15/18, at 4:00 p.m. and lacked evidence of a smoking assessment.

During an interview on 10/15/18, at 3:44 p.m. RN-F verified there was a resident who she believed to smoke residing on the unit. RN-F identified the resident to be R455. RN-F reviewed the facility electronic medical record and revealed R455 did not have a smoking risk observation completed.

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."

During interview on 10/18/18, at 10:34 a.m. the director of nursing (DON) stated it was her expectation that a smoking assessment be completed for any resident who smoke, and care planned. The DON further indicated the resident would need to have had a cognitive assessment with the ability to leave the premises to smoke. Furthermore, the DON verified that cigarette and lighter would be locked in storage at the nurse station.

The facility policy Smoking resident effective date 10/2017, indicated "residents desiring to smoke will be offered smoking cessation methods ..., prior to being allowed to sign out to go off campus, resident will be assessed by staff using the Augustana Client Smoking Risk observation to determine if this would be a safe option. The observation will be completed on admission, quarterly, with significant change in status and PRN (as needed). Individualized approaches and directions for safety will be documented in the

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F 689	Continued From page 23 care plan."	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 690		11/29/18

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F 690	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess toileting needs to ensure appropriate interventions were provided for 1 of 5 residents (R453) reviewed for bladder continence, and who needed intermittent catheterization to drain bladder from urine. Findings include: During initial interview on 10/15/18, at 1:23 p.m. R453 stated that she required to be catheterized since her surgery in order to empty her bladder (a tube used to drain urine from the bladder). R453 further stated that she had asked the nurse to "empty her bladder as she felt full" two nights ago (10/13/18) around 5:00 a.m. but the nurse (unable to identify) indicated she was unable to complete the catheterization at that time. R453 further identified that it had taken two hours until the catheterization was completed and her urine output was almost 1000 milliliters (ml). Furthermore, R453 verbalized that she had spoken with the provider earlier in the day(10/15/18) and asked for post void residual ([PVR] the amount of urine left in the bladder after using the restroom) to be checked every six hours instead of every six hours as needed to ensure she would have her bladder checked more often. R453's Resident Face Sheet printed on 10/18/18, indicated R453 admitted to the facility on 10/11/18, and diagnoses included cervical disc disorder and chronic kidney disease.	F 690	Immediate plan of correction: R453 orders regarding straight catheterization were updated on 10/18/18. Identification of other residents: An audit was completed of other residents with straight catheter orders to ensure clarity of those orders. Measures put in place: Licensed staff have been re-educated on the policy related to properly assessing residents for urinary retention and bladder management. Monitoring mechanisms: Residents with catheter orders will be audited weekly X 4 and then monthly X 2 months to ensure proper orders are in place and being followed. Results of audits will be reviewed by the facility's QAPI committee and further monitoring will be recommended by them as indicated.	

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R453's physician admission orders 10/11/18, indicated "Patient may need straight intermittent catheterization every six hours as needed." However, the physician admission orders lacked PVR frequency and parameters.

R453's transfer orders from the hospital dated 10/11/18, indicated under discharge instructions "Patient may need straight intermittent catheterization every 6 hours" and included R453's discharge diagnoses to be cervical myelopathy (compression on the cervical spinal cord) and neurogenic bladder (bladder dysfunction).

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.

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

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AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

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F 690	Continued From page 26	F 690		

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 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 800 ml of urine output;
-On 10/14/18, at 12:55 p.m. the TAR indicated R453 was catheterized and had 525 ml of urine output;

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F 690	Continued From page 27 -On 10/14/18, at 5:30 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 600 ml of urine output; -On 10/15/18, at 9:30 a.m. indicated R453 was catheterized and had 550 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. During interview on 10/18/18, at 10:44 a.m. the interim director of nursing (IDON) stated it was her expectation for the nurse to assess R453's bladder status at least one time during their scheduled eight hour shift. On 10/18/18, at 10:35 a.m. R453's bladder assessment was requested and not provided. The facility policy Catheter: Straight/ Indwelling revised date 5/2017, indicated "straight catheterization is performed to ....relieve urinary retention.	F 690		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the dialysis	F 698	Immediate Plan of Correction: R134 orders related to dialysis dressing	11/29/18

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F 698	Continued From page 28 access site was assessed and a person centered plan of was developed for 1 of 2 residents (R134) reviewed for dialysis. Findings include: R134's admission Minimum Data Set (MDS) dated 10/5/18, identified R134 was cognitively intact, required extensive assist with activities of daily living (ADL's), and identified R134 received dialysis. R134's face sheet printed on 10/18/18, indicated R134 had active diagnoses of dependence on renal dialysis, end stage renal disease and identified R134 admitted to the facility on 9/28/18. 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). 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	F 698	and checking of bruit were corrected on 10/17/18. Identification of Other Residents: All other residents on dialysis were reviewed to ensure orders were accurate in reflecting the correct type of dialysis access and care of that access. Measures Put in Place: Licensed staff was educated regarding different types of dialysis access and the care of those access points. Licensed staff were re-educated on the dialysis care policy. Monitoring Mechanisms: A random sample of residents on dialysis will be audited weekly X 4 weeks and then monthly X 2 months to ensure that orders and care plan match the type of care the resident needs related to dialysis. Results of the audits will be reviewed by the facility□s QAPI committee and further monitoring will be recommended by them as indicated. Person responsible for compliance: Director of nursing is responsible for compliance.	

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F 698	Continued From page 29	F 698		

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.

On 10/16/18, at 2:41 p.m. R134's care plan was reviewed. The care plan dated 10/1/18, revealed R134 received dialysis and indicated R134 had a right arm dialysis port. The care plan directed facility staff to check dialysis shunt for bruit (a sound heard to verify artery patency) every shift and remove the dressing from the dialysis fistula (intravenous access site for dialysis) site "on the shift after they return from dialysis."

Review of R134's physician orders dated 9/28/18, included: "check shunt for bruit every shift", "check access site for signs and symptoms of infection. Record location notify medical doctor as indicated," and "remove dressing from dialysis site on the shift after they return from dialysis."

Review of R134's treatment administration record (TAR) was completed on 10/16/18, at 3:02 p.m. directed the facility staff to "check shunt for bruit every shift", "check access site for signs and symptoms of infection. Record location, notify medical doctor as indicated," and "remove dressing from dialysis site on the shift after they return from dialysis." The TAR further identified R134's dressing had been removed four times during the month of October.

During interview on 10/17/18, at 8:33 a.m. licensed practical nurse (LPN)-B verified R134's dressing change was to be completed on evening shift after return from dialysis.

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F 698	Continued From page 30	F 698		

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 the dialysis clinic staff. The clinic manager further 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 and information was gathered from the physician orders and resident progress notes.

During interview on 10/17/18, at 2:24 p.m. RN-I, reviewed R134's dialysis care plan and physician orders. RN-I acknowledged R134's dressing was 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 resident assessment. Furthermore, RN-I verified R134 did have a CVC and indicated it was her expectation facility staff not change the dressing and to notify the 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

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F 698	Continued From page 31 admission The DON further stated the nurse would need to obtain accurate orders for dialysis access site care following the completed assessment. During interview on 10/18/18, at 12:29 p.m. RN-F stated she was unable to locate a dialysis assessment. A facility policy titled Dialysis dated 6/28/18, identified "1. Residents who require dialysis will receive ...comprehensive person-centered plan of care. 2. Facility will provide ongoing assessment of the resident's condition ..."	F 698		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete annual performance evaluations (PE) for 4 of 5 nursing assistants (NA-B, NA-C, NA-D, NA-E) who had worked at the facility for over a year. Findings Include: Review of NA personnel files on 10/18/18, revealed the following: NA-B's date of hire (DOH) with the facility was	F 730	Immediate Plan of Correction: Performance evaluations for NA-B, NA-C, NA-D, NA-E were completed by 11/29/18. Identification of Other Residents: Human resource director completed an audit of NAR staff to determine if any other performance evaluations are overdue. Measures Put in Place: The 1st of each month the HR Director	11/29/18

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F 730	Continued From page 32 9/12/11, and last PE completed by the facility was 9/8/17. NA-C's DOH with the facility was 6/20/17, and last PE completed was 8/31/17. NA-D's DOH with the facility was 10/2/89, and last PE completed was 8/7/15. NA-E's DOH with the facility was 5/8/15, and last PE completed was 9/8/17. On 10/18/18, at 1:49 p.m. Interim Director of Nursing (IDON) verified NA-B, NA-C, NA-D and NA-E's last PE date completed. IDON stated the nurse managers completed the PEs and she expected them to be completed "yearly", one year after the last PE completed "30 days before or after". IDON confirmed NA-B, NA-C, NA-D and NA-E's PEs were not current, and had not been completed timely. IDON also confirmed Human Resources had no other PEs completed for NA-B, NA-C, NA-D and NA-E. The facility Performance Evaluation policy dated 11/15, indicated "... Employee performance evaluations shall be conducted yearly..."	F 730	will send a list the employees due for their evaluation that month. The list will be given to each of the nurse managers. If HR Director does not receive completed evaluation by the 25th she will notify the nurse manager, Director of Nursing and Administrator to assure completion by end of the month. Monitoring Mechanisms: An audit of 10 NARs per month will be completed X 3 months to ensure that performance evaluations have been completed on time. Results of those audits will be reviewed by the facility□s QAPI committee and further monitoring will be recommended by them as indicated. Person responsible for compliance: Director of Human Resources is responsible for compliance.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed	F 732		11/29/18

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F 732	Continued From page 33 and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to display Daily Nursing Hours Log (DNHL) at the beginning of each shift, update DNHL routinely, and keep logs accessible for 18 months. This had the potential to affect all 161 residents residing in the facility and their visitors.	F 732	Immediate Plan of Correction: Staffing coordinators updated their process to include updating the census and staffing hours per policy. Identification of Other Residents: No other residents impacted. Measures Put in Place: Education was	

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F 732	Continued From page 34 Findings include: On 10/17/18, at 8:50 a.m. the DNHL dated 10/16/18, was observed posted on the bulletin board on the 1st floor across from the elevators. On 10/18/18, at 8:47 a.m. the DNHL dated 10/17/18, was observed with Registered Nurse (RN)-J. RN-J verified the log dated 10/17/18, and stated the log needed to be hung by 9:00 a.m. daily and was posted by the schedulers and/or by the RN charge nurse when the schedulers did not work. RN-J stated the DNHL was not updated throughout the day, and only the master sheet in the book was updated. RN-J stated she had never been instructed to update the log with census or staffing changes. RN-J stated census and staffing changes did occur throughout the day. On 10/18/18, at 9:00 a.m. RN-A was observed hanging the DNHL dated 10/18/18, on the board. RN-A stated the log was hung daily at 9:00 a.m. and the log was not updated during the day, only on the Master sheet in the book was. On 10/18/18, at 9:31 a.m. Interim Director of Nursing (IDON) stated the DNHL needed to be posted daily, updated routinely throughout the day, and should be updated with any call ins, pick ups, staffing and census changes. IDON also stated when census changed staffing would be adjusted. IDON stated, "the posting [DNHL] should be an accurate picture of what staffing and census was in the building". On 10/18/18, at 12:58 p.m. Scheduler stated she had not always updated the "last minute"	F 732	completed with facility staffing coordinators on the policy for updating staffing and census information on the posted staffing hours. Monitoring Mechanisms: A random sample of dates will be audited monthly X 3 months to ensure that the posted staffing hours have been posted and updated properly. Results of these audits will be reviewed by the facility□s QAPI committee and further monitoring will be recommended by them. Person responsible for compliance: Director of nursing is responsible for compliance.	

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F 732	Continued From page 35 changes with nursing staff. Scheduler stated schedulers worked seven days a week and the RN charge posted the DNHL when schedulers did not work. Scheduler stated she updated the log with changes in hours nursing staff worked by putting up a 2nd log, but did not keep the 1st log the changes had been updated from. Scheduler stated she followed this procedure since starting at the facility. Review of 10/17/18, and 10/18/18, DNHL indicated no updated census and nursing staff changes. The facility policy Posting of Staffing Hours dated 5/21/18, indicated, "...Numbers of direct care staff will be posted by 8:30 a.m. daily" and changes to the staffing information due to call-ins or major census changes would be made for each shift as needed during the day. The policy also indicated, "...The staffing office will keep a file of staffing sheets [DNHL] for a minimum of 18 months."	F 732		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure ongoing physical and verbal behaviors were comprehensively assessed, failed to ensure person centered individualized non-pharmacological interventions were	F 744	Immediate Plan of Correction: R129 Depakene was restarted on 9/18/18 upon discovery of medication error. A discussion was held with daughter on 11/9/18 concerning on-going behaviors and getting a referral to the Associated	11/29/18

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F 744	Continued From page 36 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. In addition, the facility failed to update the physician/nurse practitioner of increased behaviors, and failed to ensure medication used to treat behaviors was administered as ordered. Findings include: R129 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. R129 was assessed as having both long and short term memory deficits and inattentive behaviors including difficulty focusing attention, being easily distractible, and difficulty keeping track of what was being said. Behavioral symptoms included both physical and verbal behaviors occurring 1-3 days of the 7 day look back period. The MDS also indicated R129 was hard of hearing, and required supervision with some activities of daily living but was independent with walking using a walker and bed mobility. R129's current care plan included a potential alteration in behavior originally identified 8/15/14, related to the diagnoses of dementia, anxiety and being hard of hearing. The care plan included one new intervention initiated 9/21/18, indicating staff were to re-approach R129 as needed when behaviors were increased. Other interventions included offer time for R129 to calm down before re-approaching. R129's care plan also indicated a problem with alteration in cognition, identifying R129 as severely impaired. R129's undated Nursing Assistant Care Sheet identified	F 744	Clinic of Psychology (ACP). On 11/14 Family has agreed to ACP referral and that referral has been made. R129 behavior care plan will be reviewed by the IDT and updated 11/15/18. Identification of Other Residents: An audit was completed of all other residents with a diagnosis of dementia to ensure their care plan includes individualized interventions. Measures Put in Place: Behavior meeting will be held with Interdisciplinary team Mon-Friday (with the exception of holidays) to allow designated time for IDT to review any noted changes in resident behaviors. IDT will review potential triggers to the change in behavior and will do a comprehensive review of residents experiencing changes in behavior. The team will develop a plan including assuring medications are being administered as ordered, notification to provider of changes, and referrals made to outside provider such as ACP as indicated. Interdisciplinary team was educated on change to our current IDT meeting structure to include review of behavioral changes. Education is being provided to licensed staff on the importance of notifying the provider of any changes in behavior and the need to comprehensively assess residents that are experiencing changes in behavior in order to determine the root cause of the change. Nursing staff will receive education on Nov 14, 16th or 19th related	

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F 744	Continued From page 37 behavioral interventions including notifying nursing of behaviors toward spouse, re-approach, and keep room orderly, 30 minute safety checks at night and report refusal of cares. During an observation on 10/15/18, at 6:28 p.m. R129 was observed in his room with a distressed look, 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. During an observation on 10/16/2018, at 2:32 p.m. R129 and his wife were observed heading out to the dining room to play BINGO. Family member (FM)- E was present and R129 demonstrated no agitated behaviors. During an interview with FM-E at 3:50 p.m., FM-E stated she believes the facility would be happy if her parents were no longer residents of the nursing home. FM-E stated she had received a risk/benefit sheet, explaining the risks of R129's behaviors if her parents stay at the facility. FM-E was aware of the increased behavior, the medication error and had pictures of blood on the floor where her father had fallen. FM-E also stated she and her brother had stayed over at the facility multiple nights in the past, and stated she believed much of R129's behavior is due to staff approach. 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.	F 744	to properly approaching residents with dementia and reporting changes in behavior to the nurse. Monitoring Mechanisms: Observation audits will be completed weekly by designated management staff. They will observe staff interactions with residents with dementia. These audits will be done weekly X 1 month and then monthly X 2 months. Results of the audits will be reviewed by the facility□s QAPI committee and further monitoring will be recommended by them as indicated. Person responsible for compliance: Director of nursing is responsible for compliance.	

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	245264	A. BUILDING _____ B. WING _____	C 10/18/2018

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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 Depakene to include a 125 mg dose each morning, in addition to the bedtime dose. The order specified the nurse practitioner (NP) was to be updated on R129's distress and behaviors in 2 weeks. The facility had inadvertently stopped the Depakene on 7/17/18. Following the discontinuation of the Depakene, the nursing progress notes from 7/24/18 through 9/15/18, revealed an increase in behaviors including refusing cares, baths and taking medications; combative towards staff; hitting, punching and biting staff; swearing and yelling at staff; pounding his wheelchair on the floor in his room; pounding on the wall; swing walker at staff; charge at staff; refusing dressing change to his legs; not letting staff help wife, wanting to call the police; trying to get wife out of her chairs, trying to get wife into bed, while she needed two person and standing lift for transfers; pacing in room; angry; grabbing staff ans spouse by arms and would not let go; agitation that led to fall with injury to head. Even though these behaviors were documented, there was no evidence the facility interdisciplinary team comprehensively reassessed R129's individualized dementia care needs, re-assessed already in place interventions, developed person-centered individualized non-pharmacological approaches, and/or sought outside professional help of a psychologist and/or psychiatrist to evaluate R129's dementia related emotional and behavioral needs.

The Nurse Practitioner (NP) progress note dated 9/11/18, listed R129's medications and did not

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include Depakene. Under assessment and plan NP indicated a diagnosis of dementia with behavioral and psychological symptoms of dementia (BPSD) that "staff approach in light of 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 discuss R129's continued behaviors. Family believes R129 behaviors can be managed with appropriate medication. Family talked about frustration with staff approach and the lack of anticipation of needs. Family is not open to stay the night as they are still recovering from doing this in the past. Family is not open to transfer to moving the couple to a new facility as they believe it create more risk for the couple. Family is not open to separating the couple as they believe it would only lead to more behaviors. NP has restarted Depakote and will slowly increase the dose to get his mood and behaviors under control. There was no evidence of additional non-pharmacological interventions developed by the interdisciplinary (IDT) team, or request made to have R129 be evaluated by outside professional services such as a psychologist or psychiatrist.
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 acknowledged an increase in R129's behaviors since the time of discontinuation.
During an interview on 10/17/18 at 10:53 a.m. NA-H stated R129 was agitated at the time of the fall on 9/15/18. NA-H stated "I turned my back on him because he was coming at me and if I turned he would only hit my back." NA-H then heard a

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noise and turned and R129 was on the floor. R129 was agitated because he was trying to help his wife and R129 did not understand that they were helping her even when we tried to explain. NA-H acknowledged that R129's agitation had increased over the summer and mostly involved protective behaviors related to R129's wife.
During interview on 10/17/2018, at 2:02 p.m. RN-C verified that R129 had not received his Depakene for 63 days due to the order being incorrectly entered into the electronic medical record. RN-C stated R129 had his first dose of Depakene again on 9/19/18 at 8:00 a.m..
Efforts to interview the NP were unsuccessful.
During an interview on 10/18/2018, at 11:39 a.m., with the interim director of nursing (IDON), she acknowledged she had only recently became aware of the medication error as she was not present in the facility during the occurrence. She verified the medication error should have been recognized sooner and the physician should have been updated regarding R129's increase in behaviors.
A facility policy "Dementia Care," last revised 11/2017, indicated a resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental and psychosocial well-being.
A facility's Behavioral Health Services policy dated 6/28/18, indicated facility staff will identify, document and inform the provider about specific details regarding changes in an individual's behavior. New or changing behavioral symptoms will be evaluated by the interdisciplinary (IDT) in order to help determine the underlying cause and to address any modifiable factors that may have contributed to the resident's change in condition.

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F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medications were	F 755	Immediate Plan of Correction: Order for polyvinyl eye drops for R448 was	11/29/18

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F 755	Continued From page 42 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 eyes 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 eye 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 moistening agent) two drops to both eyes, four times daily as needed for dry eye syndrome of lacrimal gland. R448's allergies included acetaminophen, Benadryl, bupropion, fluvoxamine, Geodon, ibuprofen, penicillin, Prozac, Seroquel and Vistaril. On 10/15/18, at 1:32 p.m. R448's medication administration record (MAR) was reviewed and indicated R448's polyvinyl alcohol eye drops	F 755	discontinued on 10/17/18. Resident has since discharged to home. Identification of Other Residents: An audit was completed of all medications being documented as not given due to not available. Follow up has been completed with 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 importance of reaching out to pharmacy and notifying the provider if a medication is not available, so a substitute medication can be ordered if indicated. Monitoring Mechanisms: An audit will be completed weekly X 8 weeks and then monthly X 1 for medications being documented as not given due to not available. Results of these audits will be reviewed by the facility□s QAPI committee and further monitoring will be completed per their recommendations as indicated. Person responsible for compliance: Director of nursing is responsible for compliance.	

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were "Drug/ Item unavailable" during the time period of 10/4/18 at 6:00 p.m. to current (10/15/18) which included an 8:00 a.m., 12:00 p.m. and 6:00 p.m. administration times. R448's MAR further identified the "as needed" Refresh classic drops had not been administered.

During interview on 10/16/18, at 1:29 p.m. licensed practical nurse (LPN)-C indicated that she was unaware of why R448's polyvinyl alcohol drops were not at the facility and stated she would need to contact the pharmacy. At 1:35 p.m. LPN-C revealed the facility pharmacy indicated the polyvinyl alcohol drops were on back order and the order for eye drops needed to be changed. LPN-C indicated she left a voice mail for the provider to obtain an order for a substitute eye drop and was awaiting a return call.

R448's nurse progress notes were reviewed:
-The note dated 10/4/18, at 11:29 p.m. indicated "contacted pharmacy, eye drop not available. To ask dr [doctor]. if they want to change to different eye drop;" the note lacked evidence that R448's provider was updated;
-The note dated 10/13/18, at 1:43 p.m. indicated "Pt polyvinyl alcohol 1.4% eye drops are on major backorder per pharmacy. Pharmacy suggested to get new orders for either Systane or Refresh eye drops. Writer will update oncoming shift and have provider notified on Monday;"
-The note dated 10/16/18, at 1:42 p.m. (note made after surveyor discussed concerns with facility staff) indicated "polyvinyl eye drops is not available and per pharmacy [it's back order] and they don't know when it's gonna be available. Left v/m [voice message] for NP [nurse

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practitioner] to check if we can change it to a different medication. Pt also had prn (as needed) refresh that helps with her dry eyes. Will pass on to PM nurse to f/u with NP."

During interview on 10/17/18, at 11:34 a.m. LPN-D stated she had given R448's Refresh eye drops from the as needed list in the morning. LPN-D further stated she would need to call the pharmacy to see why the polyvinyl eye drops were not at the facility. At 12:27 p.m. LPN-D indicated the provider needed to change R448's polyvinyl eye drop order as these were unavailable at the facility pharmacy. LPN-D further indicated the provider had changed R448's polyvinyl eye drop order to Refresh eye drops scheduled three times daily.

During a telephone interview on 10/18/18, at 9:56 a.m. the facility pharmacy consultant indicated that if the pharmacy did not have a medication available, the pharmacy would notify the facility upon receipt of the order through a fax. The pharmacy consultant stated the facility would then be expected to see if the provider wanted to wait for the medication to come into the pharmacy for delivery or if the provider would rather order an alternative medication. The pharmacy consultant identified that once the information was relayed to the facility that the medication was unavailable, it would be up to the facility to follow-up and continue to check-in when the medication would become available and/or ask the provider to order an alternative.

During an interview on 10/18/18, at 10:29 a.m. the director of nursing (DON) stated that if the prescribed medication was unavailable by the

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F 755	Continued From page 45 following day, that it was her expectation to contact the provider and obtain an order for an alternative medication. The facility policy Medication Management dated 8/20/18, indicated "c. If unable to obtain medications, contact the resident's physician."	F 755		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced 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: 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	F 760	Immediate Plan of Correction: R129 Depakene was restarted on 9/18/18 upon discovery of medication error. A discussion was held with daughter on 11/9/18 concerning on-going behaviors and getting a referral to the Associated Clinic of Psychology. The daughter will discuss with brother and sister before agreeing to ACP. Augustana□s Interdisciplinary team meets every day for clinical rounds (except weekends) and discussion was held regarding residents□ behaviors and then discovery of medication error. Beginning 9/21 the IDT discussed residents behaviors and care plan reviewed to ensure appropriate individualized interventions are in place. Identification of Other Residents: All residents on psychotropic medications are being audited to ensure all medications orders, target behaviors and monitoring are correct and in place per	11/29/18

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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., 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	policy. Measures Put in Place: Health information staff and licensed nurses have been re-educated on the transcription of orders policy and the importance of verification of orders. Licensed staff have been re-educated on the importance of notifying the provider with changes in behavioral symptoms. Monitoring Mechanisms: A random sample of 10 charts per week will be reviewed for new orders and accuracy of those orders X 4 weeks and then monthly X 2 months. Results of the audits will be reviewed by the facility□s QAPI committee and further monitoring will be recommended by them as indicated. Person responsible for compliance: Director of nursing is responsible for compliance.	

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F 760	Continued From page 47 Depakene to include a 125 mg dose each morning, in addition to the bedtime dose. The order specified the nurse practitioner (NP) was to be updated on R129's distress and behaviors in 2 weeks. However, the order was transcribed to indicate an end date in two weeks, and following the 7/17/18 doses, the Depakene had been discontinued. In addition, there was no indication the NP or physician had ever received an update regarding the impact the additional Depakene had on R129's behaviors. Following the discontinuation of the Depakene, the nursing progress notes revealed an increase in behaviors: - Progress note dated 7/24/18, 2:03 p.m., indicated R129 punched staff members arm causing medications to spill on the floor as the staff approached wife. R129 stated, "leave her alone she is fine." - Progress note dated 8/3/18, at 9:54 p.m., indicated R129 became agitated while wife was receiving cares. - Progress note dated 8/5/18, at 1:39 p.m., identified R129 as agitated, pulling the dressings off his legs and refusing to allow the nurse to assist. - Progress note dated 8/17/18, at 6:54 a.m., indicated R129 did not sleep, using call light most of the night, trying to prevent care givers from entering his side of the room and hitting staff. - Progress note dated 8/19/18 at 1:09 a.m., R129 was holding wife, preventing care givers from providing care, hitting and biting staff. R129 was swearing at staff. - Progress note dated 8/20/18, at 2:25 p.m., R129 or wife would not go to dining room for breakfast, R129 constantly pressing call light, yelled, "they stole all our stuff."; combative and	F 760		

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F 760	Continued From page 48 protective over wife. Nursing assistant (NA) stated R129 was pounding his wheelchair on the floor in his room. - Progress note dated 8/22/2018, at 6:21 a.m., R129 difficult to redirect, continues to pound on wall and push assist light. R129 angry that wife does not have pants on. Multiple attempts to help spouse. R129 continues to swing walker at staff, charge at staff. - Progress note dated 9/4/1,8 at 11:23 a.m., R129 displayed 'major behaviors' today; pounding on wall, yelling, hitting several staff, aggressive when staff tried to assist wife. They were an hour late for breakfast. Refused medications. - Progress note dated 9/5/18 at 2:25 p.m., R129 refused dressing change to his legs. - Progress note dated 9/7/18, at 1:44 a.m., 129 did not want staff to help wife, kicking them out, wanting the police called. Calmed down a little, still up trying to help wife. - Progress note dated 9/7/18, at 6:28 a.m., R129 on call light all night. - Progress note dated 9/8/18, at 5:27 p.m., R 129 refused bath. - Progress note dated 9/10/18 2:18 p.m., R129 pressing call light multiple times, even after assist offered, bang on the wall with his fist and stand in the door waiting for help. Trying to get wife out of her chair. - Progress note dated 9/11/18, 10:25 p.m., NA stated R129 trying to get wife into bed. Wife is a 2 person/standing lift assist for transfers. When NAs approached to assist, R129 became agitated, grabbed spouse and staff by arms and would not let go. NA eventually got wife to bed. R129 still angry, pacing in room and pushing emergency call light. R129 believes family and police are on their way.	F 760		

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	245264	A. BUILDING _____ B. WING _____	C 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

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F 760	Continued From page 49 - The Nurse Practitioner (NP) progress note dated 9/11/18, listed R129's medications, but did not include Depakene. Under assessment and plan NP indicated a diagnosis of dementia with behavioral and psychological symptoms of dementia (BPSD) that "staff approach in light of hearing impairment matters. Certainly, also continue mood stabilizer." - A progress note dated 9/15/18 at 11:10 a.m., 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., registered nurse (RN)-C verified R129 had not	F 760		

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F 760	Continued From page 50 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 although the transcribing nurse stated in retrospect she should have clarified the order, the nurse received education. However, the nurse who double checked the order transcription had not received further education. Efforts to interview the NP were unsuccessful. During an interview on 10/18/2018, at 11:39 a.m., with the interim director of nursing (IDON), she acknowledged she had only recently became aware of the medication error as she was not present in the facility during the occurrence. She verified the medication error should have been recognized sooner and the physician should have been updated regarding R129's increase in behaviors. The facility's 10/2018, Transcription of Orders policy indicated the nurse that verifies the order will review order documentation and ensure a full transcription of orders has been signed and is accurate.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		11/29/18

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F 761	Continued From page 51 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to date eye drops when opened and discard eye drops when expired. This had the potential to affect 2 of 9 residents (R128, R7) with eye drops on the third floor. Findings include: On 10/15/18, at 12:15 p.m. a review of two medication carts on third floor with RN-A. There were two bottles of eye drops for R128, Ketotifen fumarate eye drops (used to relieve itchy eyes) hand an open date of 8/28 and Durezol eye drops (used to treat eye pain and inflammation) had an open date of 8/20. The other resident, R7, had Rhopressa eye drops (used to lowers eye pressure); it did not indicate when the bottle was open for use.	F 761	Immediate Plan of Correction: Eye gtts were immediately reordered and the old eye gtts were removed from cart. New eye gtts arrived from Merwins Pharmacy on 10/18/18. Identification of Other Residents: A complete audit of medication carts will be completed to ensure all medications are properly dated when opened. Measures Put in Place: Licensed staff and TMAs have been re-educated on the policy for labeling and storage of medications. Monitoring Mechanisms: Audits will be completed on 50 % of the medication carts weekly X 4 and then	

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F 761	Continued From page 52 On 10/15/18, at 12:15 p.m. registered nurse (RN)-A verified Ketotifen fumarate and Durezol drops should not be use after being open for 28 days. RN-A verified Rhopressa did not have an 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 time period. On 10/18/2018, at 0845 a.m. RN-B confirmed	F 761	monthly X 2 months to ensure compliance with labeling and proper storage of medications. Results of these audits will be reviewed by the facility QAPI committee and further monitoring will be recommended by them as indicated. Person responsible for compliance: Director of nursing is responsible for compliance.	

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F 761	Continued From page 53	F 761		

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.

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".

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	245264	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/17/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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)	K 000	EPOC	

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

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K 000	Continued From page 1 Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Augustana Health Care Center of Apple Valley is a 3-story building with a full basement. The building was constructed in 1983, and was determined to be of Type II(222) construction. The building has an automatic sprinkler system installed throughout in accordance with NFPA 13 Standard for Installation of Automatic Sprinkler Systems (2010 edition). The facility has a fire alarm system with smoke detection throughout the corridor system and in the common spaces. The fire alarm system is monitored for automatic fire department notification and is installed in accordance with NFPA 72 "The National Fire Alarm Code" (2010 edition). Hazardous areas have automatic fire detection that is on the fire alarm system in accordance with the Minnesota State Fire Code (2015 edition). The facility has a capacity of 178 beds and had a census of 156 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 914 SS=F	Electrical Systems - Maintenance and Testing 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: The facility failed to comply with Life Safety Code (6.3.4 (NFPA 99) Electrical Systems - Maintenance and Testing This deficient practice could affect the safety of all (156) the residents with in the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM	K 914	Created a list of resident rooms and outlet locations to inspect on a yearly bases. Completed all resident room inspections of electrical outlets.	11/1/18

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K 914	Continued From page 3 on 10/17/2018, observation and documentation reviewed revealed the following: The Facility does not have a current electrical outlet testing completed per NFPA 99-6.3.4. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 914		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and	K 918		11/1/18

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K 918	Continued From page 4 circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Electrical Systems - Essential Electric System Maintenance and Testing This deficient practice could affect the safety of all (156) the residents with in the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 10/17/2018, observations and staff interview revealed the following: There is no emergency stop button located for the generator for the healthcare facility. Per NFPA 110: 5.6.5.6. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 918	Hired a licensed electrical technician to install a Red push to shut off switch for generator ,located at head end switch panel (Transfer switch) Put in place clearly marked sign next to switch that indicates emergency power shut off.	

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

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

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

Please feel free to call me with any questions.

Sincerely,

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

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	00979	A. BUILDING: _____ B. WING _____	C 10/18/2018

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AUGUSTANA HCC OF APPLE VALLEY	14650 GARRETT AVENUE APPLE VALLEY, MN 55124

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

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	00979	A. BUILDING: _____ B. WING _____	C 10/18/2018

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 10/15/18 through 10/18/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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. In addition, complaint investigation(s) were also completed at the time of the licensing survey. 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	2 000		

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2 000	Continued From page 2 after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 335	MN Rule 4658.0130 Employees' Personnel Records A current personnel record must be maintained for each employee and be stored in a confidential manner. The personnel records for at least the most recent three-year period must be maintained by the nursing home. The records must be available to representatives of the department and must contain: A. the person's name, address, telephone number, gender, Minnesota license, certification, or registration number, if applicable, and similar identifying data; B. a list of the individual's training, experience, and previous employment; C. the date of employment, type of position currently held, hours of work, and attendance records; and D. the date of resignation or discharge. Employee health information, including the record of all accidents and those illnesses	2 335		11/29/18

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2 335	Continued From page 3 reportable under part 4605.7040, must be maintained and stored in a separate employee medical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete annual performance evaluations (PE) for 4 of 5 nursing assistants (NA-B, NA-C, NA-D, NA-E) who had worked at the facility for over a year. Findings Include: Review of NA personnel files on 10/18/18, revealed the following: NA-B's date of hire (DOH) with the facility was 9/12/11, and last PE completed by the facility was 9/8/17. NA-C's DOH with the facility was 6/20/17, and last PE completed was 8/31/17. NA-D's DOH with the facility was 10/2/89, and last PE completed was 8/7/15. NA-E's DOH with the facility was 5/8/15, and last PE completed was 9/8/17. On 10/18/18, at 1:49 p.m. Interim Director of Nursing (IDON) verified NA-B, NA-C, NA-D and NA-E's last PE date completed. IDON stated the nurse managers completed the PEs and she expected them to be completed "yearly", one year after the last PE completed "30 days before or after". IDON confirmed NA-B, NA-C, NA-D and NA-E's PEs were not current, and had not been completed timely. IDON also confirmed Human	2 335	See plan of correction for corresponding Federal tag.	

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2 335	Continued From page 4 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 CORRECTION: Twenty-one (21) days.	2 335		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced	2 830		11/29/18

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2 830	Continued From page 5 by: 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 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	2 830	See POC for corresponding Federal tag.	

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2 830	Continued From page 6 store his own cigarettes and lighter in his room. On 10/15/18, at 3:23 p.m. R455 was observed outside on the facility property, inside the gazebo, in the middle of the facility driveway smoking a cigarette. R455 did not have any burns on his fingers and/or clothing and extinguished his cigarette onto the ground. During interview on 10/15/18, at 2:33 p.m. registered nurse (RN)-H stated there were not any residents who smoke residing on the unit. During an interview on 10/15/18, at 2:35 p.m. RN-E stated the facility was non-smoking and if a resident had cigarettes and/or a lighter, the facility would lock the items up until a smoking assessment was completed. R455's Cognitive Performance Test (CPT) dated 10/4/18, indicated intact cognition. R455's admission Care Area Assessment dated 10/5/18, lacked evidence of R455's nicotine dependence and tobacco use. R455's Minimum Data Set (MDS) dated 10/5/18, indicated R455's did not currently use tobacco. R455's care plan revised 10/16/18, identified R455 as a "smoker or history of smoking." However, the individualized care plan lacked evidence of interventions related to R455's smoking and/ or smoking history. 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 to smoke pt did x [times] 2."	2 830		

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2 830	Continued From page 7 R455's medical record was reviewed on 10/15/18, at 4:00 p.m. and lacked evidence of a smoking assessment. During an interview on 10/15/18, at 3:44 p.m. RN-F verified there was a resident who she believed to smoke residing on the unit. RN-F identified the resident to be R455. RN-F reviewed the facility electronic medical record and revealed R455 did not have a smoking risk observation completed. 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." During interview on 10/18/18, at 10:34 a.m. the director of nursing (DON) stated it was her expectation that a smoking assessment be completed for any resident who smoke, and care planned. The DON further indicated the resident would need to have had a cognitive assessment with the ability to leave the premises to smoke. Furthermore, the DON verified that cigarette and lighter would be locked in storage at the nurse station. The facility policy Smoking resident effective date 10/2017, indicated "residents desiring to smoke will be offered smoking cessation methods ..., prior to being allowed to sign out to go off campus, resident will be assessed by staff using the Augustana Client Smoking Risk observation to determine if this would be a safe option. The observation will be completed on admission, quarterly, with significant change in status and PRN (as needed). Individualized approaches and directions for safety will be documented in the	2 830		

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2 830	Continued From page 8 care plan." R134's admission Minimum Data Set (MDS) dated 10/5/18, identified R134 was cognitively intact, required extensive assist with activities of daily living (ADL's), and identified R134 received dialysis. R134's face sheet printed on 10/18/18, indicated R134 had active diagnoses of dependence on renal dialysis, end stage renal disease and identified R134 admitted to the facility on 9/28/18. 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). 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.	2 830		

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2 830	Continued From page 9 On 10/16/18, at 2:41 p.m. R134's care plan was reviewed. The care plan dated 10/1/18, revealed R134 received dialysis and indicated R134 had a right arm dialysis port. The care plan directed facility staff to check dialysis shunt for bruit (a sound heard to verify artery patency) every shift and remove the dressing from the dialysis fistula (intravenous access site for dialysis) site "on the shift after they return from dialysis." Review of R134's physician orders dated 9/28/18, included: "check shunt for bruit every shift", "check access site for signs and symptoms of infection. Record location notify medical doctor as indicated," and "remove dressing from dialysis site on the shift after they return from dialysis." Review of R134's treatment administration record (TAR) was completed on 10/16/18, at 3:02 p.m. directed the facility staff to "check shunt for bruit every shift", "check access site for signs and symptoms of infection. Record location, notify medical doctor as indicated," and "remove dressing from dialysis site on the shift after they return from dialysis." The TAR further identified R134's dressing had been removed four times during the month of October. During interview on 10/17/18, at 8:33 a.m. licensed practical nurse (LPN)-B verified R134's dressing change was to be completed on 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	2 830		

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2 830	Continued From page 10 the dialysis clinic staff. The clinic manager further 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 and information was gathered from the physician orders and resident progress notes. During interview on 10/17/18, at 2:24 p.m. RN-I, reviewed R134's dialysis care plan and physician orders. RN-I acknowledged R134's dressing was 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 resident assessment. Furthermore, RN-I verified R134 did have a CVC and indicated it was her expectation facility staff not change the dressing and to notify the 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. During interview on 10/18/18, at 12:29 p.m. RN-F stated she was unable to locate a dialysis	2 830		

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2 830	Continued From page 11 assessment. A facility policy titled Dialysis dated 6/28/18, identified "1. Residents who require dialysis will receive ...comprehensive person-centered plan of care. 2. Facility will provide ongoing assessment of the resident's condition ..." R129 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. R129 was assessed as having both long and short term memory deficits and inattentive behaviors including difficulty focusing attention, being easily distractible, and difficulty keeping track of what was being said. Behavioral symptoms included both physical and verbal behaviors occurring 1-3 days of the 7 day look back period. The MDS also indicated R129 was hard of hearing, and required supervision with some activities of daily living but was independent with walking using a walker and bed mobility. R129's current care plan included a potential alteration in behavior originally identified 8/15/14, related to the diagnoses of dementia, anxiety and being hard of hearing. The care plan included one new intervention initiated 9/21/18, indicating staff were to re-approach R129 as needed when behaviors were increased. Other interventions included offer time for R129 to calm down before re-approaching. R129's care plan also indicated a problem with alteration in cognition, identifying R129 as severely impaired. R129's undated Nursing Assistant Care Sheet identified behavioral interventions including notifying nursing of behaviors toward spouse,	2 830		

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2 830	Continued From page 12 re-approach, and keep room orderly, 30 minute safety checks at night and report refusal of cares. During an observation on 10/15/18, at 6:28 p.m. R129 was observed in his room with a distressed look, 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. During an observation on 10/16/2018, at 2:32 p.m. R129 and his wife were observed heading out to the dining room to play BINGO. Family member (FM)- E was present and R129 demonstrated no agitated behaviors. During an interview with FM-E at 3:50 p.m., FM-E stated she believes the facility would be happy if her parents were no longer residents of the nursing home. FM-E stated she had received a risk/benefit sheet, explaining the risks of R129's behaviors if her parents stay at the facility. FM-E was aware of the increased behavior, the medication error and had pictures of blood on the floor where her father had fallen. FM-E also stated she and her brother had stayed over at the facility multiple nights in the past, and stated she believed much of R129's behavior is due to staff approach. 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.	2 830		

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2 830	Continued From page 13 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 Depakene to include a 125 mg dose each morning, in addition to the bedtime dose. The order specified the nurse practitioner (NP) was to be updated on R129's distress and behaviors in 2 weeks. The facility had inadvertently stopped the Depakene on 7/17/18. Following the discontinuation of the Depakene, the nursing progress notes from 7/24/18 through 9/15/18, revealed an increase in behaviors including refusing cares, baths and taking medications; combative towards staff; hitting, punching and biting staff; swearing and yelling at staff; pounding his wheelchair on the floor in his room; pounding on the wall; swing walker at staff; charge at staff; refusing dressing change to his legs; not letting staff help wife, wanting to call the police; trying to get wife out of her chairs, trying to get wife into bed, while she needed two person and standing lift for transfers; pacing in room; angry; grabbing staff ans spouse by arms and would not let go; agitation that led to fall with injury to head. Even though these behaviors were documented, there was no evidence the facility interdisciplinary team comprehensively reassessed R129's individualized dementia care needs, re-assessed already in place interventions, developed person-centered individualized non-pharmacological approaches, and/or sought outside professional help of a psychologist and/or psychiatrist to evaluate R129's dementia related emotional and behavioral needs. The Nurse Practitioner (NP) progress note dated	2 830		

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2 830	Continued From page 14 9/11/18, listed R129's medications and did not include Depakene. Under assessment and plan NP indicated a diagnosis of dementia with behavioral and psychological symptoms of dementia (BPSD) that "staff approach in light of 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 discuss R129's continued behaviors. Family believes R129 behaviors can be managed with appropriate medication. Family talked about frustration with staff approach and the lack of anticipation of needs. Family is not open to stay the night as they are still recovering from doing this in the past. Family is not open to transfer to moving the couple to a new facility as they believe it create more risk for the couple. Family is not open to separating the couple as they believe it would only lead to more behaviors. NP has restarted Depakote and will slowly increase the dose to get his mood and behaviors under control. There was no evidence of additional non-pharmacological interventions developed by the interdisciplinary (IDT) team, or request made to have R129 be evaluated by outside professional services such as a psychologist or psychiatrist. 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 acknowledged an increase in R129's behaviors since the time of discontinuation. During an interview on 10/17/18 at 10:53 a.m. NA-H stated R129 was agitated at the time of the	2 830		

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2 830	Continued From page 15 fall on 9/15/18. NA-H stated "I turned my back on him because he was coming at me and if I turned he would only hit my back." NA-H then heard a noise and turned and R129 was on the floor. R129 was agitated because he was trying to help his wife and R129 did not understand that they were helping her even when we tried to explain. NA-H acknowledged that R129's agitation had increased over the summer and mostly involved protective behaviors related to R129's wife. During interview on 10/17/2018, at 2:02 p.m. RN-C verified that R129 had not received his Depakene for 63 days due to the order being incorrectly entered into the electronic medical record. RN-C stated R129 had his first dose of Depakene again on 9/19/18 at 8:00 a.m.. Efforts to interview the NP were unsuccessful. During an interview on 10/18/2018, at 11:39 a.m., with the interim director of nursing (IDON), she acknowledged she had only recently became aware of the medication error as she was not present in the facility during the occurrence. She verified the medication error should have been recognized sooner and the physician should have been updated regarding R129's increase in behaviors. A facility policy "Dementia Care," last revised 11/2017, indicated a resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental and psychosocial well-being. A facility's Behavioral Health Services policy dated 6/28/18, indicated facility staff will identify,	2 830		

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2 830	Continued From page 16 document and inform the provider about specific details regarding changes in an individual's behavior. New or changing behavioral symptoms will be evaluated by the interdisciplinary (IDT) in order to help determine the underlying cause and to address any modifiable factors that may have contributed to the resident's change in condition. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure the facility properly assessed residents for safe smoking procedures, dialysis site care and dementia care. 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 CORRECTION: Twenty-one (21) days.	2 830		
2 885	MN Rule 4658.0525 Subp. 1 Rehabilitation Nursing Care; Program required Subpart 1. Program required. A nursing home must have an active program of rehabilitation nursing care directed toward assisting each resident to achieve and maintain the highest practicable physical, mental, and psychosocial well-being according to the comprehensive resident assessment and plan of care described in parts 4658.0400 and 4658.0405. Continuous efforts must be made to encourage ambulation and purposeful activities. This MN Requirement is not met as evidenced by:	2 885		11/29/18

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2 885	Continued From page 17 Based on observation, interview and document review, the facility failed to provide restorative services for 2 of 4 residents (R85, R114) reviewed for rehabilitation. Findings include: R85's quarterly Minimum Data Set (MDS) dated 9/11/18, indicated R85's cognition was intact, needed limited staff assistance to transfer and walking in room and corridor was marked as a"-" (meaning not assessed). R85's significant change MDS dated 6/18/18, indicated R85 needed limited staff assistance with transfers and walked in her room and in the corridor with staff supervision. R85's careplan dated 3/29/18, indicated nursing staff were to walk R85 in the hallway using walker two times daily to maintain gains made in physical therapy and R85 ambulated 15-30 feet. On 10/15/18, at 10:23 a.m. R85 told surveyor she was supposed to get walked two times a day but "almost always" was not walked in the mornings. R85 stated nursing assistant (NA)-C would tell her he was "too busy" to walk her. R85 stated she was "going down hill" from not being walked. R85 stated she was supposed to be walked down the hall as far as she could go twice a day and the distance kept track of. R85 stated she was also attending therapy for strengthening exercises. On 10/17/18, at 1:01 p.m. registered nurse (RN)-A stated R85 was on a restorative program for walking and also attended therapy. RN-A stated R85 was doing a lot better now since therapy had gotten R85 up and walking.	2 885	See plan of correction for corresponding Federal tag.	

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2 885	Continued From page 18 Review of R85's Point of Care History for walking dated 9/1/18-10/18/18, indicated 25 x NAs documented "Not Performed", 46 x NAs documented "unanswered" and 24 x documented completed by NAs. On 10/18/18, at 12:24 p.m. RN-B stated R85 had weakness in her legs, wanted to walk on her own, and could now walk short distances. RN-B looked at the Point of Care documentation on the computer from 10/10/18, through 10/18/18, and stated it looked like R85 was not being walked every morning. Based on data walking had only been completed three times (times), documented "Not Performed" five times, and documented "unanswered" ten times by the NAs. RN-B stated walking was a part of R85's rehabilitation program to be completed by the NAs twice a day and had been unaware R85 was not being walked every morning and/or afternoon. On 10/18/18, at 12:47 p.m. NA-G stated R85 had a walking program and would walk R85 in the morning as far as she could walk and document. NA-G stated R85 six months ago could not walk, had improved with therapy and had never refused to walk. NA-G stated R85 was able to walk in her room with her walker independently to and from the bathroom, but needed her wheelchair for further distances like to the dining room. On 10/18/18, at 1:31 p.m. NA-C stated R85 was on a walking program and could walk on some days 50 feet or more. NA-C stated he tried to walk R85 in the mornings but could not always do that when less than full staffed. NA-C stated he told the nurses when he could not walk R85	2 885		

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2 885	Continued From page 19 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 leg syndrome related to MS, hemiplegia, 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 intact. The Care Assessment Area (CAA) dated 1/15/18, did not include any information 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)	2 885		

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2 885	Continued From page 20 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	2 885		

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2 885	Continued From page 21 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." 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 assistance. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to	2 885		

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2 885	Continued From page 22 residents' on staff assisted rehabilitation nursing programs based on residents' comprehensively assessed needs. The DON or designee could conduct audits of residents on staff assisted walking programs to ensure their needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 885		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess toileting needs to ensure appropriate interventions were provided for 1 of 5 residents (R453) reviewed for bladder continence, and who needed intermittent catheterization to drain	2 910	See plan of correction for corresponding Federal tag.	11/29/18

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2 910	Continued From page 23 bladder from urine. Findings include: During initial interview on 10/15/18, at 1:23 p.m. R453 stated that she required to be catheterized since her surgery in order to empty her bladder (a tube used to drain urine from the bladder). R453 further stated that she had asked the nurse to "empty her bladder as she felt full" two nights ago (10/13/18) around 5:00 a.m. but the nurse (unable to identify) indicated she was unable to complete the catheterization at that time. R453 further identified that it had taken two hours until the catheterization was completed and her urine output was almost 1000 milliliters (ml). Furthermore, R453 verbalized that she had spoken with the provider earlier in the day(10/15/18) and asked for post void residual ([PVR] the amount of urine left in the bladder after using the restroom) to be checked every six hours instead of every six hours as needed to ensure she would have her bladder checked more often. R453's Resident Face Sheet printed on 10/18/18, indicated R453 admitted to the facility on 10/11/18, and diagnoses included cervical disc disorder and chronic kidney disease. R453's physician admission orders 10/11/18, indicated "Patient may need straight intermittent catheterization every six hours as needed." However, the physician admission orders lacked PVR frequency and parameters. R453's transfer orders from the hospital dated 10/11/18, indicated under discharge instructions "Patient may need straight intermittent	2 910		

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2 910	Continued From page 24	2 910		

catheterization every 6 hours" and included R453's discharge diagnoses to be cervical myelopathy (compression on the cervical spinal cord) and neurogenic bladder (bladder dysfunction).

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.

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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2 910	Continued From page 25 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 800 ml of urine output; -On 10/14/18, at 12:55 p.m. the TAR indicated R453 was catheterized and had 525 ml of urine output; -On 10/14/18, at 5:30 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 600 ml of urine output; -On 10/15/18, at 9:30 a.m. indicated R453 was catheterized and had 550 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.	2 910		

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2 910	Continued From page 26 During interview on 10/18/18, at 10:44 a.m. the interim director of nursing (IDON) stated it was her expectation for the nurse to assess R453's bladder status at least one time during their scheduled eight hour shift. On 10/18/18, at 10:35 a.m. R453's bladder assessment was requested and not provided. The facility policy Catheter: Straight/ Indwelling revised date 5/2017, indicated "straight catheterization is performed to ....relieve urinary retention. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure the facility properly assessed residents for urinary retention and bladder management. 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 CORRECTION: Twenty-one (21) days.	2 910		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is	21545		11/29/18

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21545	Continued From page 27 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 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	21545		

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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: 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	See plan of correction for corresponding Federal tag.	

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21545	Continued From page 29 A review of R129's progress notes identified the following behavior documentation: Progress note dated 6/13/18, at 2:23 p.m., 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 Depakene to include a 125 mg dose each morning, in addition to the bedtime dose. The order specified the nurse practitioner (NP) was to be updated on R129's distress and behaviors in 2 weeks. However, the order was transcribed to indicate an end date in two weeks, and following the 7/17/18 doses, the Depakene had been discontinued. In addition, there was no indication	21545		

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the NP or physician had ever received an update regarding the impact the additional Depakene had on R129's behaviors.

Following the discontinuation of the Depakene, the nursing progress notes revealed an increase in behaviors:
- Progress note dated 7/24/18, 2:03 p.m., indicated R129 punched staff members arm causing medications to spill on the floor as the staff approached wife. R129 stated, "leave her alone she is fine."
- Progress note dated 8/3/18, at 9:54 p.m., indicated R129 became agitated while wife was receiving cares.
- Progress note dated 8/5/18, at 1:39 p.m., identified R129 as agitated, pulling the dressings off his legs and refusing to allow the nurse to assist.
- Progress note dated 8/17/18, at 6:54 a.m., indicated R129 did not sleep, using call light most of the night, trying to prevent care givers from entering his side of the room and hitting staff.
- Progress note dated 8/19/18 at 1:09 a.m., R129 was holding wife, preventing care givers from providing care, hitting and biting staff. R129 was swearing at staff.
- Progress note dated 8/20/18, at 2:25 p.m., R129 or wife would not go to dining room for breakfast, R129 constantly pressing call light, yelled, "they stole all our stuff."; combative and protective over wife. Nursing assistant (NA) stated R129 was pounding his wheelchair on the floor in his room.
- Progress note dated 8/22/2018, at 6:21 a.m., R129 difficult to redirect, continues to pound on wall and push assist light. R129 angry that wife does not have pants on. Multiple attempts to help spouse. R129 continues to swing walker at staff,

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21545	Continued From page 31	21545		

charge at staff.
- Progress note dated 9/4/1,8 at 11:23 a.m., R129 displayed 'major behaviors' today; pounding on wall, yelling, hitting several staff, aggressive when staff tried to assist wife. They were an hour late for breakfast. Refused medications.
- Progress note dated 9/5/18 at 2:25 p.m., R129 refused dressing change to his legs.
- Progress note dated 9/7/18, at 1:44 a.m., 129 did not want staff to help wife, kicking them out, wanting the police called. Calmed down a little, still up trying to help wife.
- Progress note dated 9/7/18, at 6:28 a.m., R129 on call light all night.
- Progress note dated 9/8/18, at 5:27 p.m., R 129 refused bath.
- Progress note dated 9/10/18 2:18 p.m., R129 pressing call light multiple times, even after assist offered, bang on the wall with his fist and stand in the door waiting for help. Trying to get wife out of her chair.
- Progress note dated 9/11/18, 10:25 p.m., NA stated R129 trying to get wife into bed. Wife is a 2 person/standing lift assist for transfers. When NAs approached to assist, R129 became agitated, grabbed spouse and staff by arms and would not let go. NA eventually got wife to bed. R129 still angry, pacing in room and pushing emergency call light. R129 believes family and police are on their way.
- The Nurse Practitioner (NP) progress note dated 9/11/18, listed R129's medications, but did not include Depakene. Under assessment and plan NP indicated a diagnosis of dementia with behavioral and psychological symptoms of dementia (BPSD) that "staff approach in light of hearing impairment matters. Certainly, also continue mood stabilizer."
- A progress note dated 9/15/18 at 11:10 a.m.,

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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., 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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21545	Continued From page 33 although the transcribing nurse stated in retrospect she should have clarified the order, the nurse received education. However, the nurse who double checked the order transcription had not received further education. Efforts to interview the NP were unsuccessful. During an interview on 10/18/2018, at 11:39 a.m., with the interim director of nursing (IDON), she acknowledged she had only recently became aware of the medication error as she was not present in the facility during the occurrence. She verified the medication error should have been recognized sooner and the physician should have been updated regarding R129's increase in behaviors. The facility's 10/2018, Transcription of Orders policy indicated the nurse that verifies the order will review order documentation and ensure a full transcription of orders has been signed and is accurate. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper transcription of medication orders to prevent medication errors. The DON or designee, along with the pharmacist, could audit transcription of medication orders on a regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21545		
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv.	21550		11/29/18

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21550	Continued From page 34 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure medications were 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 eyes 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 eye 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	21550	See plan of correction for corresponding Federal tag.	

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moistening agent) two drops to both eyes, four times daily as needed for dry eye syndrome of lacrimal gland. R448's allergies included acetaminophen, Benadryl, bupropion, fluvoxamine, Geodon, ibuprofen, penicillin, Prozac, Seroquel and Vistaril.

On 10/15/18, at 1:32 p.m. R448's medication administration record (MAR) was reviewed and indicated R448's polyvinyl alcohol eye drops were "Drug/ Item unavailable" during the time period of 10/4/18 at 6:00 p.m. to current (10/15/18) which included an 8:00 a.m., 12:00 p.m. and 6:00 p.m. administration times. R448's MAR further identified the "as needed" Refresh classic drops had not been administered.

During interview on 10/16/18, at 1:29 p.m. licensed practical nurse (LPN)-C indicated that she was unaware of why R448's polyvinyl alcohol drops were not at the facility and stated she would need to contact the pharmacy. At 1:35 p.m. LPN-C revealed the facility pharmacy indicated the polyvinyl alcohol drops were on back order and the order for eye drops needed to be changed. LPN-C indicated she left a voice mail for the provider to obtain an order for a substitute eye drop and was awaiting a return call.

R448's nurse progress notes were reviewed:
-The note dated 10/4/18, at 11:29 p.m. indicated "contacted pharmacy, eye drop not available. To ask dr [doctor]. if they want to change to different eye drop;" the note lacked evidence that R448's provider was updated;
-The note dated 10/13/18, at 1:43 p.m. indicated "Pt polyvinyl alcohol 1.4% eye drops are on major backorder per pharmacy. Pharmacy

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suggested to get new orders for either Systane or Refresh eye drops. Writer will update oncoming shift and have provider notified on Monday;"
-The note dated 10/16/18, at 1:42 p.m. (note made after surveyor discussed concerns with facility staff) indicated "polyvinyl eye drops is not available and per pharmacy [it's back order] and they don't know when it's gonna be available. Left v/m [voice message] for NP [nurse practitioner] to check if we can change it to a different medication. Pt also had prn (as needed) refresh that helps with her dry eyes. Will pass on to PM nurse to f/u with NP."

During interview on 10/17/18, at 11:34 a.m. LPN-D stated she had given R448's Refresh eye drops from the as needed list in the morning. LPN-D further stated she would need to call the pharmacy to see why the polyvinyl eye drops were not at the facility. At 12:27 p.m. LPN-D indicated the provider needed to change R448's polyvinyl eye drop order as these were unavailable at the facility pharmacy. LPN-D further indicated the provider had changed R448's polyvinyl eye drop order to Refresh eye drops scheduled three times daily.

During a telephone interview on 10/18/18, at 9:56 a.m. the facility pharmacy consultant indicated that if the pharmacy did not have a medication available, the pharmacy would notify the facility upon receipt of the order through a fax. The pharmacy consultant stated the facility would then be expected to see if the provider wanted to wait for the medication to come into the pharmacy for delivery or if the provider would rather order an alternative medication. The pharmacy consultant identified that once the information was relayed to the facility that the

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21550	Continued From page 37 medication was unavailable, it would be up to the facility to follow-up and continue to check-in when the medication would become available and/or ask the provider to order an alternative. During an interview on 10/18/18, at 10:29 a.m. the director of nursing (DON) stated that if the prescribed medication was unavailable by the following day, that it was her expectation to contact the provider and obtain an order for an alternative medication. The facility policy Medication Management dated 8/20/18, indicated "c. If unable to obtain medications, contact the resident's physician." SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure the facility orders medications timely. 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 CORRECTION: Twenty-one (21) days.	21550		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician.	21565		11/29/18

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21565	Continued From page 38 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). 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	21565	See plan of correction for corresponding Federal tag.	

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21565	Continued From page 39 able to self-administer medications after the teaching had been done and the resident was observed. RN-E indicated the teaching would be documented in the nurse progress notes and a self-administration of medication consent form would also be completed. During an interview on 10/15/18, at 3:44 p.m. RN-F, unit nurse manager, indicated R447 did not have an order for SAM of neb treatment. RN-F further reviewed R447's SAM observation and verified that R447's SAM observation indicated R447 was not able to self-administer medications. On 10/18/18, at 10:33 a.m. the director of nursing (DON) stated it was her expectation that a SAM observation be completed for all residents. The DON further indicated that if the resident was deemed unable to SAM it would be her expectation the nurse would remain present while administering all medication. The facility policy Self Administration of Medications dated 7/25/18, included: "3. If the resident wishes to self-administer medications, complete the applicable observation/ assessment form in the EHR. " The policy further noted "12. When a nebulizer treatment is set up for the resident and the resident is left alone with the treatment running, that is considered self-administration of medications and the above steps will be followed." SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure the facility properly assessed residents for safe SAM procedures.	21565		

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21565	Continued From page 40 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 CORRECTION: Twenty-one (21) days.	21565		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to date eye drops when opened and discard eye drops when expired. This had the potential to affect 2 of 9 residents (R128, R7) with eye drops on the third floor. Findings include: On 10/15/18, at 12:15 p.m. a review of two medication carts on third floor with RN-A. There were two bottles of eye drops for R128, Ketotifen fumarate eye drops (used to relieve itchy eyes) hand an open date of 8/28 and Durezol eye drops (used to treat eye pain and inflammation) had an open date of 8/20. The other resident, R7, had Rhopressa eye drops (used to lowers eye pressure); it did not indicate when the bottle was open for use. On 10/15/18, at 12:15 p.m. registered nurse (RN)-A verified Ketotifen fumarate and Durezol drops should not be use after being open for 28 days. RN-A verified Rhopressa did not have an	21620	See plan of correction for corresponding Federal tag.	11/29/18

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21620	Continued From page 41 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 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.	21620		

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21620	Continued From page 42 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 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 compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21620		

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21810	MN St. Statute 144.651 Subd. 6 Patients & 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 review, the facility failed to ensure the call light 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 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	21810	See plan of correction for corresponding Federal tag.	11/29/18

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21810	Continued From page 44 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: 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 audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21810		

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21810	Continued From page 45 (21) days.	21810		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the	21830		11/29/18

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21830	Continued From page 46 esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law	21830		

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21830	Continued From page 47 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 by: Based on observation, interview and document review, the facility failed to honor 1 of 6 residents (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 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	21830	See plan of correction for corresponding Federal tag.	

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21830	Continued From page 48	21830		

also stated she wanted to use a bedpan for bowel movements, however, staff often encouraged her to defecate in her incontinent brief. R114 said the last time she requested to use the bedpan, she was told she had a pad on and and to go in that if she wanted. R114 stated, "That was hard to take." R114 stated she was not incontinent of bowel and felt staff did not want to take time to allow her to use the bedpan unless she was already in bed. R114 also said it was "normal" for her to have a bowel movement in her pad. She further explained it was uncomfortable and not good for her skin.

During an interview on 10/16/18, at 3:15 p.m., the nursing assistant (NA)-F stated her shift usually ended at 10:00 p.m.. NA-F was aware R114 preferred to stay up until 10:00 p.m. and explained on the evenings she cared for R114, she talked to her about going to bed earlier than her preferred bedtime and "sometimes she did not mind." She further explained she was not allowed to work a full shift and if she stayed past 10:00 p.m. she would get "late points."

On 10/16/18, at 3:40 p.m., R114 was interviewed again and explained she did not want to go to bed early (before 10:00 p.m.) and did not want to put her night gown on at 8:00 p.m. and sit in her wheelchair. R114 did not want staff to interrupt her TV programs. R114 explained staff was aware of her preferences because it was documented on her careplan.

On 10/16/18 at 3:47 p.m., a registered RN-B said she expected staff to follow the care plan of all residents. When staff was scheduled for a shortened shift, she expected another staff to assist R114 to bed as her care plan indicated.

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21830	Continued From page 49 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 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 mental status and R114 had intact. 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	21830		

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21830	Continued From page 50 bowel and required assistance of two staff. No further direction regarding toileting needs or choices were addressed. R114's Care Plan revised 10/2/18, indicated R114 preferred to go to bed at 10:00 p.m. She preferred not to get ready for bed earlier than 10:00 p.m., and directed staff not to use the bed pan for bowel movements unless she asked for it. During an interview on 10/18/18, at 1:10 p.m., the Interim Director of Nursing, stated she expected cares and assistance for all residents would be provided as their care plan indicated and as residents residents preferred/chose, when possible. The Augustana Care Policy: Observing Resident Dignity,Choices and Preferences, effective date 4/16 indicated: It is the standard of care that all residents will be treated with respect and dignity at all times. The facility will also put protocols in place to honor resident's choices and preferences per plan of care and reasonable accommodation. Resident's choices and preferences will be reviewed upon admission and at quarterly care conferences. These preferences will be care planned as appropriate. Resident's choices and preferences that could affect their care negatively or lead to unsafe/poor outcomes will be discussed with the resident and a risk to benefits review will be completed and documented if needed. Residents will be encouraged to voice their concerns and needs at all times to ensure their needs, choices and preferences are honored. All staff are responsible.	21830		

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21830	Continued From page 51 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop policies and procedures to ensure facility has a system to know residents' likes and dislikes, including choices regarding activities of daily living and daily routines. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		
21840	MN St. Statute 144.651 Subd. 12 Patients & Residents of HC Fac.Bill of Rights Subd. 12. Right to refuse care. Competent residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the resident's medical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure advanced directives for emergency care and treatment were accurately reflected in all areas of the residents medical records to ensure residents wishes would be implemented correctly in an emergency situation for 1 of 1 residents (R58) reviewed for advanced directives.	21840	See plan of correction for corresponding Federal tag.	11/29/18

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21840	Continued From page 52 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". There was no evidence in R58's medical record that discrepancies between the POLST, facesheet and physician's orders were verified and clarified. On 10/16/18, at 9:23 a.m. registered Nurse (RN)-B confirmed R58's code status in the	21840		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00979	A. BUILDING: _____ B. WING _____	C 10/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21840	Continued From page 53	21840		

electronic medical record (EMR) did not match the code status in R58's POLST. RN-B explained social services should have given the POLST to a health unit coordinator (HUC) to update R58's code status in her chart.

On 10/16/18, at 9:35 a.m. licensed practical nurse (LPN)-E shared she preferred looking in the paper chart for a resident's code status as it was more specific and the code status could also be found in the EMR.

On 10/18/18, at 10:05 a.m. interim director of nursing (IDON) indicated she was made aware of the concern with R58's code status, and the POLST not matching the EMR. DON expressed the records updating process was not followed in R58's case.

The facility's Physician Order for Life Sustaining Treatment (POLST) policy dated 06/21/2018, indicated "8. Social Services or designee will document in the resident medical record if the resident has a Health Care Directive. This is also noted on the Face Sheet of the resident's electronic health record".

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to advance directives. The DON or designee, could provide training for all nursing staff related to advance directives. The quality assessment and assurance committee could perform random audits to ensure compliance.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.