P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS
FOR NURSING HOMES

Hand Delivered on March 5, 2019.

March 5, 2019

Administrator
The Estates At St Louis Park LLC
3201 Virginia Avenue South
Saint Louis Park, MN 55426

Re: Project # H5148183, H5148193, H5148194

Dear Administrator:

On January 31, 2019, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 19, 2018 with orders received by you electronically on January 9, 2019.

State licensing orders issued pursuant to the last survey completed on December 19, 2018, found not corrected at the time of this January 31, 2019 revisit and subject to penalty assessment are as follows:

20830 - MN Rule 4658.0520 Subp. 1 -- Adequate And Proper Nursing Care; General $350.00

The details of the violations noted at the time of this revisit completed on January 31, 2019 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of $ per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered:

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Shellae Dietrich, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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.

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

Enclosure

cc: Licensing and Certification File
Kami Fiske-Downing, Licensing and Certification Program
Penalty Assessment Deposit Staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00943	A. BUILDING: ______ B. WING ______	R-C **01/31/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT ST LOUIS PARK LLC	**3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426**

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On January 29, 2019 and January 31, 2019, the MN Department of Health completed an on-site licensing revisit to follow up on licensing orders issued as a result of a licensing survey completed on December 19, 2018. During this visit it was determined that the following correction order was NOT corrected. This uncorrected order will	2 000		

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2 000	Continued From page 1 remain in effect and will be reviewed at the next site visit. To be reviewed for possible penalty assessment. 0830 - Adequate and Proper Nursing Care Complaints H5148183, H5148194, H5148193 were found to be corrected. This facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
{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 by: Uncorrected based on the following findings.The original licensing order issued on 12/19/18 will remain in effect. Penalty assessment issued.	{2 830}		

{2 830} Continued From page 2 {2 830}

Based on interview and document review, the facility failed to comprehensively assess falls in an effort to determine causal factors for 1 of 3 residents (R6) reviewed for accidents. This resulted in actual harm for R6 who sustained a hip fracture following a fall in the facility. The facility also failed to provide services for dementia care for 1 of 3 residents (R7) reviewed with dementia.

Findings include:

R6's annual Minimum Data Set (MDS) dated 11/30/18, indicated he was moderately cognitively impaired, required extensive assist of one staff for transfers and toileting, did not ambulate during the assessment period and was unsteady during transfers. The MDS further indicated R6 was frequently incontinent of bowel, always incontinent of bladder and sustained two or more falls since the previous assessment. R6's care plan identified a risk for falls secondary to a history of falls, difficulty walking and diagnosis of dementia. A Care Area Assessment (CAA) for falls dated 11/30/18, indicated the following: CAA triggered for falls related to cognitive impairment and use of medications. Resident had three falls this quarter, one which sent him to the hospital because of a laceration. Resident is at risk for fall with injury, pain and overall decline.

R6's care plan dated 9/18/18, was reviewed. Interventions included: complete bowel and bladder assessments as needed, apply footwear to prevent slipping, offer toileting when indicated and encourage call night use. The care plan further indicated R6 was unlikely to use his call light.

Review of R6's Fall Review Evaluations and

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{2 830}	Continued From page 3	{2 830}		

correlating facility Progress Notes identified the following:

-Progress note dated 10/19/18, indicated R6 fell attempting to self transfer and sustained a laceration to his forehead. R6 was reminded to use his call light, physican notified and R6 was sent to the hospital. A second noted dated 10/19/18, indicated R6 returned with five sutures to his forehead. The medical record lacked evidence the fall was reviewed for causal factors.

-Progress Note dated 11/1/18, indicated R6 was noted sitting on the floor in front of his wheel chair at 6:45 a.m. R6 was reminded to use his call light. A correlating Incident Review dated 11/1/18, indicated R6 was incontinent at the time of the fall but lacked current or new fall interventions put into place.

-Progress Note dated 11/5/18, indicated R6 was found sitting on the floor between his bed and wheel chair after supper at 6:30 p.m. A follow up note dated 11/5/18, indicated R6 was reminded to use the call light for help, incontinent of bowel and bladder and had a small stool. The record lacked evidence of an incident report.

-Progress Note dated 11/20/18, indicated at 4:20 a.m. staff heard a "big bang" in the nearby room. R6 was found on the floor. R6 hit his head on the floor resulting in a swollen forehead on the right side and complained of hip pain. A correlating Incident Review and Analysis dated 11/20/18, indicated R6 self transferred and did not lock wheel chair brakes. Current interventions included a clutter free environment. Fall reviewed with nurse practitioner and guardian during care conference and considered adding auto lock brakes to wheel chair. Guardian requested to wait

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{2 830}	Continued From page 4	{2 830}		

Continued From page 4

until therapy could evaluate. The review further indicated prior falls were reviewed. Times of falls: 1:41 a.m. (no date) attempting to self transfer from bed, 11/1/18, 6:45 a.m. attempting to transfer bed to wheel chair, bed noted to be wet. 11/5/18, 6:30 p.m. attempting to transfer from bed to wheel chair, 11/20/18, attempting to transfer from bed to wheel chair. Complete new pain assessment, currently receives no pain medications.

Review of R6's pain assessments identified a scheduled MDS pain assessment completed 11/30/18, that did not identify any pain.

-Progress Note date 12/7/18, indicated R6 was found lying on the floor in the bathroom at 1:30 p.m. R6 stated, "I lost my balance when I transferred to the bathroom." R6 reminded to call for assistance. A correlating Incident Review and Analysis dated 12/10/18, indicated R6 was trying to transfer to the toilet at the time of fall. No current interventions were identified nor were new interventions implemented.

-Progress Note dated 1/3/19, indicated at 6:15 p.m. R6 was found lying on the floor on his back by his bed. Noted old scabs on both knees, old bruises to top of both hands. A correlating Incident Review dated 1/7/19, did not identify causal factors. Current interventions indicated, "I will have pharmacy do a med [medication] review." The report lacked evidence of further analysis.

-Progress note dated 1/8/19, indicated R6 was complaining of pain on his left lower abdomen and was sent to the hospital for evaluation.

Review of a hospital history and physical dated

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{2 830}	Continued From page 5	{2 830}		

1/8/19, indicated R6 presented to the emergency department with diffuse abdominal pain. Per nursing home staff he had been increasingly confused and agitated over the last several days. R6 poor historian but able to indicate he had lower abdominal pain, worse on the right side. Initially a urinalysis was obtained and foley catheter (urinary) inserted with removal of large amount of urine. The following day, pain did not improve and a computed tomography (CT or CAT scan, allows doctors to see inside your body using a combination of X-rays and a computer to create pictures of your organs, bones, and other tissues) was obtained which showed a right comminuted and displaced femoral neck fracture.

During interview on 1/31/19, at 11:02 a.m. licensed practical nurse (LPN)-A stated R6 had been having an increase in the number of falls. LPN-A stated R6 had not been having increased behaviors but kept thinking he could transfer himself. She stated R6 used to be able to transfer independently but over time his ability decreased and could not remember to ask for help. LPN-A stated the guardian had called and wanted to know what could be done about the falls and LPN-C stated the facility did not use bed alarms or mats on the floor. LPN-A stated at the time of R6's falls she was the unit coordinator but was still working on the floor passing medications and completing treatments. In regard to the process for follow up after a fall, LPN-A stated she completed the Incident Review and Analysis form to go over any causative factors she could find for the fall and any measures to prevent future falls. She stated while the falls were reported to the interdisciplinary team, the incident reports were only completed by her. She stated when R6 fell on 10/19/18, and sustained the head laceration an incident report was not completed, on 11/1/18,

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{2 830}	Continued From page 6	{2 830}		

when he fell and had been incontinent, LPN-A stated, "I think I got therapy for him." After the fall on 11/20/18, LPN-A stated R6 had an x-ray done but she was not aware of it. LPN-A stated when R6 was hospitalized on 1/8/19, she called and was told by nursing that R6 had a hip fracture and due to a heart condition could not have surgery and the next thing she knew he had passed away. LPN-A indicated the fracture was a result of the fall on 1/3/19.

During interview on 1/31/19, at 11:27 a.m. the director of nursing (DON) stated following a fall the nurses complete an incident form and the fall was discussed with the interdisciplinary team to determine if further action needed to take place. The DON stated the nurse manager was expected to fill out the Incident Analysis and stated, "we found out that wasn't happening as often as it should have."

R7's medical record was reviewed and a facility Progress Note dated 9/22/18, indicated R7 admitted to the facility from the hospital due to a brain bleed. R7 spoke only Ukrainian and daughter would be at the facility most days to translate but stated R7 should have an interpreter.

The director of social services (DSS) at the hospital clinic was contacted on 1/29/19. On 2/7/19, at 2:37 p.m. an interview with a hospital clinic DSS was conducted. The DSS stated R7 was dropped off by a transportation driver for a clinic appointment on 10/3/18 and stated the transport driver brought R7 to the front desk and left him there. She stated R7 had paperwork that indicated he suffered from dementia and was a fall risk. The DSS stated R7 was dressed in

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{2 830}	Continued From page 7	{2 830}		

pajamas and repeatedly attempted to stand up from his wheel chair and disrobe. Clinic staff called the nursing home who told them they knew they should not have dropped R7 off alone but did not have sufficient staffing to send someone with him. The facility further reported to the clinic staff they thought since R7 needed and interpreter, they thought the interpreter would take care of him.

R7's Initial/Comprehensive Careplan dated 9/25/18, identified a self care deficit related to legal blindness, dementia and falls and a cognition defect related to diagnosis of dementia and only Russian speaking

R7's admission Minimum Data Set dated 9/29/18, indicated he was severely cognitively impaired, required extensive assistance with all activities of daily living and usually understood others and could usually be understood. A care area assessment (CAA) dated 9/29/18, identified cognitive loss/dementia and indicated R7 was at risk for mood, behavior and safety issues. The CAA further identified a communication defect and indicated R7 only spoke Russian.

A Progress Note dated 10/1/18, indicated R7 may not be able to go to a scheduled appointment on 10/3/18 due to transportation not being available in the evening.

During interview on 1/31/19, at 2:04 p.m. the director of nursing (DON) stated for a resident who had dementia, depending on how impaired they were the facility would arrange to have a friend or family member sent with to appointments. As far as an interpreter, the DON stated he would expect the clinic or hospital to

Minnesota Department of Health

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{2 830}	Continued From page 8 have their own.	{2 830}		

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
January 9, 2019

Administrator
The Estates At St Louis Park Llc
3201 Virginia Avenue South
Saint Louis Park, MN 55426

RE: Project Number H5148183, H5148191, H5148192, H5148193, and H5148194

Dear Administrator:

On December 19, 2018, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted 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 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 remedy(ies) 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 March 9, 2019.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 9, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 9, 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 March 9, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Estates At St Louis Park Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 9, 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), 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, Office of Health Facilities Complaints, 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 June 19, 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.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245148	A. BUILDING ______ B. WING ______	C 12/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT ST LOUIS PARK LLC	**3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 12/18/18, to 12/19/18, an abbreviated standard survey was conducted to investigate complaint(s) #H5148183, H5148191, H5148192, H5148193, H5148194. The facility is not in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. During the survey complaint(s) H5148183 and H5148194 were found to be substantiated at F684 and H5148193 was substantiated at F684 and F697. The facility is enrolled in the electronic Plan of Correction (ePOC) and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and implement interventions for non-pressure related skin concerns for 1 of 1 resident (R2). This resulted in actual harm for R2 who experienced progressive	F 684	R2 has had a weekly skin assessment and received appropriate treatments to manage existing skin conditions per facility policy. All residents at risk of skin breakdown have the potential to be	1/25/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/18/2019

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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F 684	Continued From page 1 decline of a skin condition and uncontrolled pain resulting in hospitalization. In addition, the facility failed to follow physician orders for 1 of 1 resident (R1) reviewed for catheter. Findings include: R2's prospective payment system 14 day minimum data set (MDS) 12/1/18, indicated she was moderately cognitively impaired, required extensive assistance from two staff for activities of daily living (ADL)'s and had moisture associated skin damage (MASD). The MDS further indicated R2 experienced frequent pain that limited her day to day functioning. R2's initial care plan dated 11/15/18, identified problems including: self care deficit with ADLs, and a potential for alteration in skin integrity related to impaired mobility and incontinence. Interventions directed staff to perform weekly skin assessments and to provide skin treatments as ordered. An untitled, undated nursing assistant care sheet, directed staff to assist with turning and repositioning every two hours and as needed. On 12/18/18, R2 was continuously observed from 6:25 a.m. to 9:25 a.m. At 6:25 a.m. R2 was lying in bed. At 9:07 a.m. nursing assistants (NA)-A and NA-B entered R2's room to perform morning cares. R2 stated, "Please, I'm very uncomfortable, I need to roll over, come on, I'm very uncomfortable, Please move me, oh, come on please roll me, I'm very uncomfortable, please help me, Oh my God, please help me." At 9:11 a.m. NA-A left the room and returned with supplies, the staff still had not repositioned R2. At 9:16 a.m. RN-A entered R2's room. RN-A stated, "her [R2's] skin is very broken down." At 9:18 a.m. R2 stated, "I'd like to get off my butt." NA-A	F 684	affected. A facility wide audit is complete as of 1/25/19 and residents have had a weekly skin assessment per care plan and facility policy; treatments have been initiated as appropriate. All residents will receive weekly skin assessments per care plan and facility policy. Licensed nursing staff and appropriate unlicensed assistive personnel have been educated on skin assessment policy and procedures, and management of new and ongoing wounds which includes timely reporting and implementation of treatments. In addition to all other nursing staff, nursing management team have been re-educated on their role in auditing and ensuring compliance with these policies. Skin assessment and wound management policy has been reviewed and remains current. DNS or designee will audit for completion of weekly skin inspections, timeliness of reporting, implementation of treatments and pertinent notifications for no less than 2 months; QAPI committee will review results and provide further recommendations for continuing audits. R1 had a urology appointment scheduled on 1/8/19. He went to the hospital on 12/25/18 and did not return to facility until 1/10/19. Urology was addressed while at the hospital, however another follow up appointment was scheduled for the resident in February 2019. All residents with physicians orders have the potential to be affected. A facility wide audit is complete as of 1/25/18 and all physicians orders for current residents	

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F 684	Continued From page 2 and NA-B removed R2's incontinent brief to perform cares, R2's perineal area and labia were bright red in color. RN-A stated "her [R2's] bottom is very red, she usually has a lot of pain, it always burns when they wipe her up." RN-A further stated when R2 was sitting she had the same amount of pain. When turned, R2's buttocks were also noted to be very red with multiple open areas. Review of R2's electronic health record identified the following: Weekly Skin Inspections noted: 11/15/18, Skin Assessment identified reddened area on buttocks. 11/29/18, Skin Assessment identified reddened area on buttocks. R2's medical record lacked evidence of any further skin assessment. Physician visit notes included: 11/30/18, R2 had complaints of pain in groin and buttock due to rash. 12/6/18, R2's buttocks were very red and irritated looking with erythema and slight edema. The note indicated, "Had Clotrimazole (antifungal cream) cream ordered however, they just got it in. Previous tube of cream "disappeared." Skin: buttocks very red and inflamed." 12/13/18, R2 had ongoing painful rash. R2 with painful rash all over peri-area and buttock. Staff reported R2 hollering at night. The facility's Interdisciplinary Progress Notes revealed: 12/3/18, R2's family member complained that R2 was sent home over the holiday weekend in a	F 684	have been transcribed appropriately. All physicians□ orders will be implemented in a timely manner per policy. Licensed nursing staff and health unit coordinators have been educated on policies regarding physician□s orders and appointments. DNS or designee will audit for timely scheduling of appointments and transcription of orders weekly for no less than 2 months. QAPI committee will review results and provide further recommendations for continuing audits.	

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F 684	Continued From page 3 soiled incontinent product and upon changing, R2 was wearing two incontinence products. Family stated both incontinent products were "soaked." 12/6/18 - R2's buttocks and groin areas were very red and open. R2 was uncomfortable and in pain, crying out loud. 12/6/18 - R2 finally asleep after she had a long exhausting day due to skin breakdown. 12/10/18 - R2 continued to have reddened buttocks and groin area. R2 continued to yell out loud due to discomfort in buttocks. 12/10/18 - Clotrimazole cream, apply to buttock and upper thigh area two times per day, to be delivered tomorrow. 12/11/18 - Social services received a call from Hennepin County adult protection services that they received reports that R2 had gone home for Thanksgiving with some diaper rashes and was denied pain medications. Interdisciplinary team reviewing. 12/12/18 - R2 buttocks was now red, raw and irritated. R2 was yelling out at the top of her voice in "excruciating pain." She was unable to be re-directed or comforted. Received an order to give a one time dose of Dilaudid and to continue to apply ordered cream. R2 continued to yell out in pain. During interview on 12/18/18, at 9:41 a.m. NA- B stated when R2 was admitted to the facility she'd had redness on her bottom, but no open areas. On 12/18/18, at 12:31 p.m. RN-A stated during the observation earlier that day she'd observed R2's skin to be "really red, broken down raw skin, with areas that looked like a popped blister." RN-A stated she'd seen about two of those blistered areas that were red, puffy and raw.	F 684		

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F 684	Continued From page 4	F 684		

Continued From page 4

On 12/18/18, at 12:37 p.m. NA-A was asked when R2 had been changed or repositioned prior to the 9:00 a.m. observation. NA-A stated R2 had last been taken care of by the night shift staff at 6:00 a.m.

On 12/18/18, at 1:29 a.m. RN-B stated he had been assessing R2's skin but had not documented anything. RN-B stated the nurses were looking at R2's skin every day and should have completed a skin assessment weekly. RN-B stated this was something he should have been following up on. RN-B further stated he had seen R2's skin that morning and stated, "it was a little worse than it had been the previous week." He further stated when he'd looked at her this morning, "she had a bunch of tiny little open spots."

During interview on 12/19/18, at 11:13 a.m. the director of nursing (DON) stated he knew the staff were struggling to manage R2's skin alterations and stated it had been discussed at the morning meeting. The DON stated on shower days the nurses should have completed weekly assessments and stated the nurse manager should be monitoring for completion. The DON stated the assessment should have included a visual description, and documentation of measurements, redness, and presence of pain.

During interview on 12/19/18, at 10:28 a.m. the hospital RN stated she had seen R2's skin. The Fairview RN described R2's skin as red and excoriated with open spots.

At 10:56 a.m. on 12/19/18, the certified nurse practitioner (CNP) stated R2 had a rash in her peri-area that was very tender to the touch. The

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F 684	Continued From page 5	F 684		

CNP stated she had seen the front but had not seen R2's buttocks.

During a subsequent interview on 12/19/18, at 3:00 p.m. the hospital RN stated the hospital wound nurse had seen R2 that afternoon. She read the wound nurse notes that described R2's skin as follows: Wound base with scattered, spotty areas of pink, red, raw, moist denuded tissue especially around there perineal and peri-labial areas. Right inner buttock contained two small superficial opening less than one centimeter each and two small scabs around the per-anal area. R2's skin alteration was described as "painful" by the wound nurse.

A policy related to skin assessment was requested but not received.

R1 was admitted to the facility on 10/4/18, with diagnoses including pressure ulcer sacral region, overactive bladder, and osteomyelitis obtained from the Admission Record dated 12/17/18.

R1's 30 day Minimum Data Set (MDS) dated 11/1/18, indicated R1 had intact cognition and R1 had an indwelling catheter (including suprapubic catheter).

On 12/18/18, at 6:27 a.m. R1 was observed awake and had the call light on. During the observation a Foley catheter collection bag was observed under the bed lying on the floor. R1 stated he had a Suprapubic catheter and pulled his shirt and showed surveyor. When asked if he had any problems with the catheter, R1 stated he had been to the hospital multiple times to have it changed because the staff at the facility stated

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F 684	Continued From page 6 they would not do it. R1 stated the catheter leaked all the time, had blockage due to sediment build-up and he would sit on wet bedding which staff did not change timely due to being short of help at times. Review of R1's Telephone Physician Order dated 10/12/18, revealed R1 had an order which read "Set up appointment with urologist due to frequent catheter leakage." There was no evidence in the record R1 had seen the urologist. During further review of the interdisciplinary (IDT) notes it was revealed on 10/6/18, 10/7/18, 10/8/18, 10/15/18, 12/4/18, and 12/5/18, multiple staff had indicated R1's Suprapubic catheter was observed and/or R1 had complained about the bypassing. The IDT note dated 10/15/18, 12:01 a.m. indicated R1's catheter was bypassing and an order had been obtained for R1 to see a urologist. The writer indicated the order was going to be followed up by the health unit coordinator (HUC) and the morning nurse. On 12/18/18, at 8:58 a.m. HUC-A when asked if R1's appointment had been set up she stated she would look through the actual physical chart to see if the referral sheet was in the chart as this was before the facility went to Point Click Care (PCC). At 9:02 a.m. HUC-A stated when R1 was admitted to the Transitional Care Unit (TCU) directed the surveyor to the HUC-B in the TCU. HUC-A verified R1's appointment was not in the calendar at the current unit. At 9:17 a.m. HUC-B reviewed the TCU calendar from 10/1/18, through 12/1/18, and verified R1 had no scheduled appointment to the urologist. HUC-B stated R1 would set up his own appointments and rides, and stated "He is with it." When asked if R1 knew	F 684		

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F 684	Continued From page 7	F 684		

he had an order to set up an appointment with urologist HUC-B stated the order had been noted by a nurse and she was not sure if this had been communicated to R1 to set the appointment. HUC-B stated she needed sometime to look through the medical record to see if R1 had seen the urologist.

On 12/18/18, at 9:27 a.m. when asked about the urologist appointment, R1 stated he did not know there was an order to schedule an appointment. Resident stated "I schedule my appointments and did not know about it until today. You are the first one to say it to me." R1 stated when he had been at the hospital, the doctor had told him all suprapubic catheters always leaked and he would have not minded going to the specialist for a second option.

On 12/18/18, at 10:37 a.m. the administrator in training stated she had looked through the medical record and was not able to see the order surveyor was inquiring about. She stated R1 was a very private person and liked to make his own appointments. Surveyor showed the administrator in training the telephone Physician Order dated 10/12/18 inside a unit three ring binder. After she reviewed the order the administrator in training stated the staff should have communicated the order to R1 so R1 would schedule the appointment.

On 12/18/18, at 9:52 a.m. the DON stated when orders were physically written in the chart the nurse or HUC pulled the red tab to alert the staff of a new order. The DON also stated on a regular day the HUC processed the orders and after hours the nurses were responsible for processing the orders and when the order was transcribed

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F 684	Continued From page 8 /completed it was supposed to be noted. The DON further stated every night, as far as he knew from when he'd been a staff nurse, the night nurse was responsible for double checking the orders to make sure they were done correctly. The DON added, "apparently that is not happening." Further, the DON stated the facility did not have a policy regarding this.	F 684		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions for pain control for 1 of 1 residents (R2). This resulted in actual harm for R2 who experienced uncontrolled pain resulting in hospitalization. Findings include: R2's prospective payment system 14 day minimum data set (MDS) dated 12/1/18, indicated she was moderately cognitively impaired, required extensive assistance from two staff for activities of daily living (ADL)'s and had moisture associated skin damage (MASD). The MDS further indicated R2 experienced frequent pain that limited her day to day functioning. The MDS identified the use of PRN pain medications but no non-pharmacological interventions. R2's	F 697	R2 has had a pain assessment on 1/3/19 and received appropriate treatments until she discharged from facility on 1/16/19. Residents who are at risk of experiencing pain have the potential to be affected. A facility wide audit is complete as of 1/25/19 and all residents have had a pain assessment per facility policy. Current residents will be assessed for pain and care plan will be updated as necessary. Residents will receive timely interventions for pain management per facility policy. Licensed nursing staff and appropriate unlicensed assistive personnel have been educated on pain management and associated policies. DNS or designee will audit pain assessments weekly for no less than 2 months. QAPI committee will review results and provide further	1/25/19

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F 697	Continued From page 9 initial care plan dated 11/15/18, identified an ADL self care deficit and a risk for alteration in comfort related to pain. The care plan directed staff to monitor and document on pain, attempt non-pharmacological interventions, administer analgesics as ordered and evaluate effectiveness. An untitled, undated nursing assistant care sheet directed staff to assist with turning and repositioning every two hours and as needed. A review of R2's Medication Administration Record (MAR) dated 12/2018, identified orders for Dilaudid 2 milligrams every three hours as needed for pain and Lidocaine cream to buttock area twice daily for pain relief. On 12/18/18, R2 was continuously observed from 6:25 a.m. to 9:25 a.m. At 6:25 a.m. R2 was lying in bed. At 9:07 a.m. nursing assistant (NA)-A and NA-B entered R2's room to perform morning cares. R2 stated, Please, I'm very uncomfortable, then stated "I need to roll over, come on, I'm very uncomfortable, Please move me, oh, come on please roll me, I'm very uncomfortable, please help me, Oh my god, please help me." At 9:11 a.m. NA-A left the room and returned with supplies, the staff still had not repositioned R2. At 9:16 a.m. RN-A entered R2's room. RN-A stated "her [R2] skin is very broken down." At 9:18 a.m. R2 stated "I'd like to get off my butt." NA-A and NA-B removed R2's incontinent brief to perform cares, R2's perineal area and labia were bright red in color. As the NA's were cleaning R2's perineal area R2 was yelling out, "It hurts, it burns, oh for gods sake it burns." RN-A stated "her bottom is very red, she usually has a lot of pain, it always burns when they wipe her up." RN-A further stated when R2 was sitting she had	F 697	recommendations for continuing audits.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT ST LOUIS PARK LLC	3201 VIRGINIA AVENUE SOUTH SAINT LOUIS PARK, MN 55426

(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 697	Continued From page 10 the same amount of pain. When turned, R2's buttocks was noted to be very red with multiple open areas. R2 had stool in her brief and as NA-A and NA-B cleaned her bottom she continually called out in pain stating, "It burns, don't you understand that?" Review of facility Progress Notes identified the following: - 12/6/18 - R2's buttocks and groin areas were very red and open. R2 was uncomfortable and in pain, crying out loud. Tylenol was given, R2 slept for about two hours and began crying out again. - 12/6/18 - R2 finally asleep after she had a long exhausting day due to skin breakdown. - 12/10/18 - R2 continued to have reddened buttocks and groin area. R2 continued to yell out loud due to discomfort in buttocks. - 12/11/18 - Social services received a call from Hennepin County adult protection services that they received reports that R2 had gone home for Thanksgiving with some diaper rashes and was denied pain medications. Interdisciplinary team reviewing. - 12/12/18 - R2 buttocks was now red, raw and irritated. R2 was yelling out at the top of her voice in "excruciating pain." She was unable to be re-directed or comforted. Received an order to give a one time dose of Dilaudid and to continue to apply ordered cream. R2 continued to yell out in pain. - 12/12/18 - Physician from dialysis called to inquire about R2's care and what we were doing to help with her pain. Writer explained that facility had reached out to primary care provider and requested pain medication. - 12/12/18 - Physician was contacted and R2 was added to his patient list for tomorrow to assess and treat increasing pain R2 has been	F 697		

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F 697	Continued From page 11	F 697		

having related to buttock redness, frequently calling out in pain last few days.
- 12/12/18 - Lidocaine cream for pain relief of buttocks not yet delivered.
- 12/13/18 - R2 screamed and yelled most of the night due to pain in buttocks. R2 received as needed Tylenol as ordered, but not helpful, calmoseptine applied.
- 12/14/18 - Doctor resumed pain management with dilaudid.
- 12/14/18 - Lidocaine cream not applied, was not available.
- 12/15/18 - 12/17/18 - Dilaudid administered for pain relief.

R2's MAR indicated she received Dilaudid twice on 12/15/18, twice on 12/16/18 and once on 12/17/18. The last dose of Dilaudid was administered on 12/17/18, at 1:40 p.m.

A facility Progress Note dated 12/18/18 indicated R2 had in increase in pain and was calling out most of the morning. R2 started the "unstoppable calling out" around 8:00 a.m. Resident was given the maximum of as needed dilaudid and it was ineffective. An hour after receiving the Dilaudid R2 was still calling out with no apparent effect. Physician order received to send R2 to the emergency room. R2 was combative with staff and paramedics, paramedics applied hand cuffs to complete the transfer.

During interview on 12/18/18, at 1:29 p.m. RN - B stated R2 had received the Dilaudid at about 9:30 a.m., even though the Progress Note written by him identified R2 had been calling out since 8:00 a.m.

During interview on 12/19/18, at 9:40 a.m. RN-A

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F 697	Continued From page 12	F 697		

was interviewed about why she did not intervene during R2's care the previous day with pain medication or the topical Lidocaine while R2 was crying out in pain. RN-A stated she thought the Lidocaine had been discontinued and stated she was not sure if it was ever received from the pharmacy. RN-A stated it was not in the medication or treatment cart and had not been available the previous day either.

On 12/19/18, at 9:45 a.m. RN-B was asked about the Lidocaine. RN-B stated, "my understanding was that it was not available, last I heard it was not here from pharmacy."

On 12/19/19 at 11:13 a.m. the director of nursing (DON) stated he would have expected the staff to use the Lidocaine prior to cares. The DON further stated if the nurse was in the room during care and heard how difficult the pain was to bear, he would expect the nurse to halt cares and intervene.

A facility policy titled Pain Management Protocol, undated, identified the facility to ensure residents with or at risk for pain had an effective pain management plan in place. The policy directed staff to identify residents with pain and collaborate to establish an effective pain management plan. Nurses to assess pain upon admission, quarterly, with change of condition and when there was on on-set of new or worsening pain. If prescribed medications are not available or there is a delay in obtaining medications, the provider would be notified and alternative interventions obtained.

Electronically delivered
January 9, 2019

Administrator
The Estates At St Louis Park Llc
3201 Virginia Avenue South
Saint Louis Park, MN 55426

Re: State Nursing Home Licensing Orders - Project Number H5148183, H5148191, H5148192, H5148193, H5148194

Dear Administrator:

The above facility was surveyed on December 17, 2018 through December 19, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

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

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

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00943	A. BUILDING: ______ B. WING ______	C **12/19/2018**

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: An abbreviated standard survey was conducted on 12/18/18, to 12/19/18, to investigate complaint(s) #H5148183, H5148191, H5148192, H5148193, H5148194. During the survey complaint(s) H5148183 and H5148194 were found to be substantiated at 4658.0520 Subp 1.	2 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/18/19

Minnesota Department of Health

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2 000	Continued From page 1 The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		
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 by: Based on observation, interview and document review, the facility failed to assess and implement interventions for non-pressure related skin concerns for 1 of 1 resident (R2). This resulted in actual harm for R2 who experienced progressive decline of a skin condition and uncontrolled pain resulting in hospitalization. In addition, the facility failed to follow physician orders for 1 of 1 resident (R1) reviewed for catheter. Findings include:	2 830	R2 has had a weekly skin assessment and received appropriate treatments to manage existing skin conditions per facility policy. All residents at risk of skin breakdown have the potential to be affected. A facility wide audit is complete as of 1/25/19 and residents have had a weekly skin assessment per care plan and facility policy; treatments have been initiated as appropriate. All residents will receive weekly skin assessments per care plan and facility policy. Licensed nursing	1/25/19

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2 830	Continued From page 2 R2: Non-pressure related skin concern: R2's prospective payment system 14 day minimum data set (MDS) 12/1/18, indicated she was moderately cognitively impaired, required extensive assistance from two staff for activities of daily living (ADL)'s and had moisture associated skin damage (MASD). The MDS further indicated R2 experienced frequent pain that limited her day to day functioning. R2's initial care plan dated 11/15/18, identified problems including: self care deficit with ADLs, and a potential for alteration in skin integrity related to impaired mobility and incontinence. Interventions directed staff to perform weekly skin assessments and to provide skin treatments as ordered. An untitled, undated nursing assistant care sheet, directed staff to assist with turning and repositioning every two hours and as needed. On 12/18/18, R2 was continuously observed from 6:25 a.m. to 9:25 a.m. At 6:25 a.m. R2 was lying in bed. At 9:07 a.m. nursing assistants (NA)-A and NA-B entered R2's room to perform morning cares. R2 stated, "Please, I'm very uncomfortable, I need to roll over, come on, I'm very uncomfortable, Please move me, oh, come on please roll me, I'm very uncomfortable, please help me, Oh my God, please help me." At 9:11 a.m. NA-A left the room and returned with supplies, the staff still had not repositioned R2. At 9:16 a.m. RN-A entered R2's room. RN-A stated, "her [R2's] skin is very broken down." At 9:18 a.m. R2 stated, "I'd like to get off my butt." NA-A and NA-B removed R2's incontinent brief to perform cares, R2's perineal area and labia were bright red in color. RN-A stated "her [R2's] bottom is very red, she usually has a lot of pain, it always burns when they wipe her up." RN-A further stated when R2 was sitting she had the same amount of pain. When turned, R2's buttocks were	2 830	staff and appropriate unlicensed assistive personnel have been educated on skin assessment policy and procedures, and management of new and ongoing wounds which includes timely reporting and implementation of treatments. In addition to all other nursing staff, nursing management team have been re-educated on their role in auditing and ensuring compliance with these policies. Skin assessment and wound management policy has been reviewed and remains current. DNS or designee will audit for completion of weekly skin inspections, timeliness of reporting, implementation of treatments and pertinent notifications for no less than 2 months; QAPI committee will review results and provide further recommendations for continuing audits. R1 had a urology appointment scheduled on 1/8/19. He went to the hospital on 12/25/18 and did not return to facility until 1/10/19. Urology was addressed while at the hospital, however another follow up appointment was scheduled for the resident in February 2019. All residents with physicians□ orders have the potential to be affected. A facility wide audit is complete as of 1/25/18 and all physicians□ orders for current residents have been transcribed appropriately. All physicians□ orders will be implemented in a timely manner per policy. Licensed nursing staff and health unit coordinators have been educated on policies regarding physician□s orders and appointments. DNS or designee will audit for timely scheduling of appointments and	

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2 830	Continued From page 3 also noted to be very red with multiple open areas. Review of R2's electronic health record identified the following: Weekly Skin Inspections noted: 11/15/18, Skin Assessment identified reddened area on buttocks. 11/29/18, Skin Assessment identified reddened area on buttocks. R2's medical record lacked evidence of any further skin assessment. Physician visit notes included: 11/30/18, R2 had complaints of pain in groin and buttock due to rash. 12/6/18, R2's buttocks were very red and irritated looking with erythema and slight edema. The note indicated, "Had Clotrimazole (antifungal cream) cream ordered however, they just got it in. Previous tube of cream "disappeared." Skin: buttocks very red and inflamed." 12/13/18, R2 had ongoing painful rash. R2 with painful rash all over peri-area and buttock. Staff reported R2 hollering at night. The facility's Interdisciplinary Progress Notes revealed: 12/3/18, R2's family member complained that R2 was sent home over the holiday weekend in a soiled incontinent product and upon changing, R2 was wearing two incontinence products. Family stated both incontinent products were "soaked." 12/6/18 - R2's buttocks and groin areas were very red and open. R2 was uncomfortable and in pain, crying out loud. 12/6/18 - R2 finally asleep after she had a long exhausting day due to skin breakdown. 12/10/18 - R2 continued to have reddened	2 830	transcription of orders weekly for no less than 2 months. QAPI committee will review results and provide further recommendations for continuing audits	

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2 830	Continued From page 4	2 830		

buttocks and groin area. R2 continued to yell out loud due to discomfort in buttocks.
12/10/18 - Clotrimazole cream, apply to buttock and upper thigh area two times per day, to be delivered tomorrow.
12/11/18 - Social services received a call from Hennepin County adult protection services that they received reports that R2 had gone home for Thanksgiving with some diaper rashes and was denied pain medications. Interdisciplinary team reviewing.
12/12/18 - R2 buttocks was now red, raw and irritated. R2 was yelling out at the top of her voice in "excruciating pain." She was unable to be re-directed or comforted. Received an order to give a one time dose of Dilaudid and to continue to apply ordered cream. R2 continued to yell out in pain.

During interview on 12/18/18, at 9:41 a.m. NA- B stated when R2 was admitted to the facility she'd had redness on her bottom, but no open areas.

On 12/18/18, at 12:31 p.m. RN-A stated during the observation earlier that day she'd observed R2's skin to be "really red, broken down raw skin, with areas that looked like a popped blister." RN-A stated she'd seen about two of those blistered areas that were red, puffy and raw.

On 12/18/18, at 12:37 p.m. NA-A was asked when R2 had been changed or repositioned prior to the 9:00 a.m. observation. NA-A stated R2 had last been taken care of by the night shift staff at 6:00 a.m.

On 12/18/18, at 1:29 a.m. RN-B stated he had been assessing R2's skin but had not documented anything. RN-B stated the nurses were looking at R2's skin every day and should

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2 830	Continued From page 5	2 830		

have completed a skin assessment weekly. RN-B stated this was something he should have been following up on. RN-B further stated he had seen R2's skin that morning and stated, "it was a little worse than it had been the previous week." He further stated when he'd looked at her this morning, "she had a bunch of tiny little open spots."

During interview on 12/19/18, at 11:13 a.m. the director of nursing (DON) stated he knew the staff were struggling to manage R2's skin alterations and stated it had been discussed at the morning meeting. The DON stated on shower days the nurses should have completed weekly assessments and stated the nurse manager should be monitoring for completion. The DON stated the assessment should have included a visual description, and documentation of measurements, redness, and presence of pain.

During interview on 12/19/18, at 10:28 a.m. the hospital RN stated she had seen R2's skin. The Fairview RN described R2's skin as red and excoriated with open spots.

At 10:56 a.m. on 12/19/18, the certified nurse practitioner (CNP) stated R2 had a rash in her peri-area that was very tender to the touch. The CNP stated she had seen the front but had not seen R2's buttocks.

During a subsequent interview on 12/19/18, at 3:00 p.m. the hospital RN stated the hospital wound nurse had seen R2 that afternoon. She read the wound nurse notes that described R2's skin as follows: Wound base with scattered, spotty areas of pink, red, raw, moist denuded tissue especially around there perineal and peri-labial areas. Right inner buttock contained

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2 830	Continued From page 6	2 830		

two small superficial opening less than one centimeter each and two small scabs around the per-anal area. R2's skin alteration was described as "painful" by the wound nurse.

A policy related to skin assessment was requested but not received.

R2- Pain Management:
R2's prospective payment system 14 day minimum data set (MDS) dated 12/1/18, indicated she was moderately cognitively impaired, required extensive assistance from two staff for activities of daily living (ADL)'s and had moisture associated skin damage (MASD). The MDS further indicated R2 experienced frequent pain that limited her day to day functioning. The MDS identified the use of PRN pain medications but no non-pharmacological interventions. R2's initial care plan dated 11/15/18, identified an ADL self care deficit and a risk for alteration in comfort related to pain. The care plan directed staff to monitor and document on pain, attempt non-pharmacological interventions, administer analgesics as ordered and evaluate effectiveness. An untitled, undated nursing assistant care sheet directed staff to assist with turning and repositioning every two hours and as needed.

A review of R2's Medication Administration Record (MAR) dated 12/2018, identified orders for Dilaudid 2 milligrams every three hours as needed for pain and Lidocaine cream to buttock area twice daily for pain relief.

On 12/18/18, R2 was continuously observed from 6:25 a.m. to 9:25 a.m. At 6:25 a.m. R2 was lying in bed. At 9:07 a.m. nursing assistant (NA)-A and NA-B entered R2's room to perform morning

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cares. R2 stated, Please, I'm very uncomfortable, then stated "I need to roll over, come on, I'm very uncomfortable, Please move me, oh, come on please roll me, I'm very uncomfortable, please help me, Oh my god, please help me." At 9:11 a.m. NA-A left the room and returned with supplies, the staff still had not repositioned R2. At 9:16 a.m. RN-A entered R2's room. RN-A stated "her [R2] skin is very broken down." At 9:18 a.m. R2 stated "I'd like to get off my butt." NA-A and NA-B removed R2's incontinent brief to perform cares, R2's perineal area and labia were bright red in color. As the NA's were cleaning R2's perineal area R2 was yelling out, "It hurts, it burns, oh for gods sake it burns." RN-A stated "her bottom is very red, she usually has a lot of pain, it always burns when they wipe her up." RN-A further stated when R2 was sitting she had the same amount of pain. When turned, R2's buttocks was noted to be very red with multiple open areas. R2 had stool in her brief and as NA-A and NA-B cleaned her bottom she continually called out in pain stating, "It burns, don't you understand that?"

Review of facility Progress Notes identified the following:
- 12/6/18 - R2's buttocks and groin areas were very red and open. R2 was uncomfortable and in pain, crying out loud. Tylenol was given, R2 slept for about two hours and began crying out again.
- 12/6/18 - R2 finally asleep after she had a long exhausting day due to skin breakdown.
- 12/10/18 - R2 continued to have reddened buttocks and groin area. R2 continued to yell out loud due to discomfort in buttocks.
- 12/11/18 - Social services received a call from Hennepin County adult protection services that they received reports that R2 had gone home for Thanksgiving with some diaper rashes and was

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denied pain medications. Interdisciplinary team reviewing.
- 12/12/18 - R2 buttocks was now red, raw and irritated. R2 was yelling out at the top of her voice in "excruciating pain." She was unable to be re-directed or comforted. Received an order to give a one time dose of Dilaudid and to continue to apply ordered cream. R2 continued to yell out in pain.
- 12/12/18 - Physician from dialysis called to inquire about R2's care and what we were doing to help with her pain. Writer explained that facility had reached out to primary care provider and requested pain medication.
- 12/12/18 - Physician was contacted and R2 was added to his patient list for tomorrow to assess and treat increasing pain R2 has been having related to buttock redness, frequently calling out in pain last few days.
- 12/12/18 - Lidocaine cream for pain relief of buttocks not yet delivered.
- 12/13/18 - R2 screamed and yelled most of the night due to pain in buttocks. R2 received as needed Tylenol as ordered, but not helpful, calmoseptine applied.
- 12/14/18 - Doctor resumed pain management with dilaudid.
- 12/14/18 - Lidocaine cream not applied, was not available.
- 12/15/18 - 12/17/18 - Dilaudid administered for pain relief.

R2's MAR indicated she received Dilaudid twice on 12/15/18, twice on 12/16/18 and once on 12/17/18. The last dose of Dilaudid was administered on 12/17/18, at 1:40 p.m.

A facility Progress Note dated 12/18/18 indicated R2 had in increase in pain and was calling out most of the morning. R2 started the "unstoppable

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calling out" around 8:00 a.m. Resident was given the maximum of as needed dilaudid and it was ineffective. An hour after receiving the Dilaudid R2 was still calling out with no apparent effect. Physician order received to send R2 to the emergency room. R2 was combative with staff and paramedics, paramedics applied hand cuffs to complete the transfer.

During interview on 12/18/18, at 1:29 p.m. RN - B stated R2 had received the Dilaudid at about 9:30 a.m., even though the Progress Note written by him identified R2 had been calling out since 8:00 a.m.

During interview on 12/19/18, at 9:40 a.m. RN-A was interviewed about why she did not intervene during R2's care the previous day with pain medication or the topical Lidocaine while R2 was crying out in pain. RN-A stated she thought the Lidocaine had been discontinued and stated she was not sure if it was ever received from the pharmacy. RN-A stated it was not in the medication or treatment cart and had not been available the previous day either.

On 12/19/18, at 9:45 a.m. RN-B was asked about the Lidocaine. RN-B stated, "my understanding was that it was not available, last I heard it was not here from pharmacy."

On 12/19/19 at 11:13 a.m. the director of nursing (DON) stated he would have expected the staff to use the Lidocaine prior to cares. The DON further stated if the nurse was in the room during care and heard how difficult the pain was to bear, he would expect the nurse to halt cares and intervene.

A facility policy titled Pain Management Protocol,

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undated, identified the facility to ensure residents with or at risk for pain had an effective pain management plan in place. The policy directed staff to identify residents with pain and collaborate to establish an effective pain management plan. Nurses to assess pain upon admission, quarterly, with change of condition and when there was on on-set of new or worsening pain. If prescribed medications are not available or there is a delay in obtaining medications, the provider would be notified and alternative interventions obtained.

R1- catheter care:
R1 was admitted to the facility on 10/4/18, with diagnoses including pressure ulcer sacral region, overactive bladder, and osteomyelitis obtained from the Admission Record dated 12/17/18.

R1's 30 day Minimum Data Set (MDS) dated 11/1/18, indicated R1 had intact cognition and R1 had an indwelling catheter (including suprapubic catheter).

On 12/18/18, at 6:27 a.m. R1 was observed awake and had the call light on. During the observation a Foley catheter collection bag was observed under the bed lying on the floor. R1 stated he had a Suprapubic catheter and pulled his shirt and showed surveyor. When asked if he had any problems with the catheter, R1 stated he had been to the hospital multiple times to have it changed because the staff at the facility stated they would not do it. R1 stated the catheter leaked all the time, had blockage due to sediment build-up and he would sit on wet bedding which staff did not change timely due to being short of help at times.

Review of R1's Telephone Physician Order dated 10/12/18, revealed R1 had an order which read

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"Set up appointment with urologist due to frequent catheter leakage." There was no evidence in the record R1 had seen the urologist.

During further review of the interdisciplinary (IDT) notes it was revealed on 10/6/18, 10/7/18, 10/8/18, 10/15/18, 12/4/18, and 12/5/18, multiple staff had indicated R1's Suprapubic catheter was observed and/or R1 had complained about the bypassing. The IDT note dated 10/15/18, 12:01 a.m. indicated R1's catheter was bypassing and an order had been obtained for R1 to see a urologist. The writer indicated the order was going to be followed up by the health unit coordinator (HUC) and the morning nurse.

On 12/18/18, at 8:58 a.m. HUC-A when asked if R1's appointment had been set up she stated she would look through the actual physical chart to see if the referral sheet was in the chart as this was before the facility went to Point Click Care (PCC). At 9:02 a.m. HUC-A stated when R1 was admitted to the Transitional Care Unit (TCU) directed the surveyor to the HUC-B in the TCU. HUC-A verified R1's appointment was not in the calendar at the current unit. At 9:17 a.m. HUC-B reviewed the TCU calendar from 10/1/18, through 12/1/18, and verified R1 had no scheduled appointment to the urologist. HUC-B stated R1 would set up his own appointments and rides, and stated "He is with it." When asked if R1 knew he had an order to set up an appointment with urologist HUC-B stated the order had been noted by a nurse and she was not sure if this had been communicated to R1 to set the appointment. HUC-B stated she needed sometime to look through the medical record to see if R1 had seen the urologist.

On 12/18/18, at 9:27 a.m. when asked about the

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urologist appointment, R1 stated he did not know there was an order to schedule an appointment. Resident stated "I schedule my appointments and did not know about it until today. You are the first one to say it to me." R1 stated when he had been at the hospital, the doctor had told him all suprapubic catheters always leaked and he would have not minded going to the specialist for a second option.

On 12/18/18, at 10:37 a.m. the administrator in training stated she had looked through the medical record and was not able to see the order surveyor was inquiring about. She stated R1 was a very private person and liked to make his own appointments. Surveyor showed the administrator in training the telephone Physician Order dated 10/12/18 inside a unit three ring binder. After she reviewed the order the administrator in training stated the staff should have communicated the order to R1 so R1 would schedule the appointment.

On 12/18/18, at 9:52 a.m. the DON stated when orders were physically written in the chart the nurse or HUC pulled the red tab to alert the staff of a new order. The DON also stated on a regular day the HUC processed the orders and after hours the nurses were responsible for processing the orders and when the order was transcribed /completed it was supposed to be noted. The DON further stated every night, as far as he knew from when he'd been a staff nurse, the night nurse was responsible for double checking the orders to make sure they were done correctly. The DON added, "apparently that is not happening." Further, the DON stated the facility did not have a policy regarding this.

SUGGESTED METHOD OF CORRECTION:

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2 830	Continued From page 13 The director of nursing or designee, could review all residents at risk for pain, skin breakdown, and use of catheters to assure they are receiving the necessary treatment/services. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure management of pain, skin related concern and catheter use. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		