Electronically delivered

September 25, 2019

Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

RE: CCN: 245183
Cycle Start Date: June 25, 2019

Dear Administrator:

On August 9, 2019, we informed you via electronic communication that we imposed enforcement remedies.

On September 6, 2019, the Minnesota Department(s) of Health completed a revisit and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

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 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 September 13, 2019, will remain in effect.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 13, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 13, 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.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, North Ridge Health And Rehab is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 17, 2019. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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:

Susie Haben, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301
Email: susie.haben@state.mn.us
Phone: 320-223-7356
Fax: 320-223-7348

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 - Health Regulation Division 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 December 25, 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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Electronically delivered
October 3, 2019

Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

RE: CCN: 245183
Cycle Start Date: June 25, 2019

Dear Administrator:

On September 6, 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 July 17, 2019.

State licensing orders issued pursuant to the last survey completed on , found not corrected at the time of this September 6, 2019 revisit and subject to penalty assessment are as follows:

S0830 -- 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 September 6, 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, § 144A.10, you will be assessed an amount of $350 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:

Susie Haben, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301
Email: susie.haben@state.mn.us

Phone: 320-223-7356
Fax: 320-223-7348

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, Program Assurance Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
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.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Enclosure

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

Electronically Submitted
August 6, 2019

Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

RE: Project Number H5183195C, H5183196C, H5183197C, and H5183198C

Dear Administrator:

On July 11, 2019, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 25, 2019. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On July 17, 2019, an extended standard survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On July 12, 2019, the situation of immediate jeopardy to potential health and safety cited at F0689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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 listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy 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 October 5, 2019.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- 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 October 5, 2019 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 5, 2019 (42 CFR 488.417 (b)).

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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 17, 2019. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of

each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, North Ridge Health And Rehab is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 17, 2019. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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:

Susie Haben, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301
Email: susie.haben@state.mn.us
Phone: 320-223-7356
Fax: 320-223-7348

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 September 25, 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 DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board.

Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

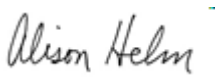
You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

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,



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Electronically Submitted
August 6, 2019

Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

RE: Project Number H5183195C, H5183196C, H5183197C, and H5183198C

REVISED LETTER
This letter replaces the letter sent on August 6, 2019 and is revised to reflect correct remedy dates.

Dear Administrator:

On July 11, 2019, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 25, 2019. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On July 17, 2019, an extended standard survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On July 12, 2019, the situation of immediate jeopardy to potential health and safety cited at F0689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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 listed below to the CMS Region V Office for

imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

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This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- 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 September 13, 2019 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 5, 2019 (42 CFR 488.417 (b)).

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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 17, 2019. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and

Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, North Ridge Health And Rehab is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 17, 2019. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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:

Susie Haben, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301
Email: susie.haben@state.mn.us
Phone: 320-223-7356
Fax: 320-223-7348

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 December 25, 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 DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an

initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

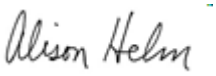
You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

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,



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	C 07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	**5430 BOONE AVENUE NORTH NEW HOPE, MN 55428**

(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 7/11/19, through 7/17/19, an abbreviated and extended survey was completed at your facility by the Minnesota Department of Health to determine if your facility was not in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. Complaint H5183197C was unsubstantiated. Complaint H5183195C was substantiated with no deficiency cited. The following complaint(s) H5183196C and H5183198C were substantiated with deficienies cited at F690 and F740 As a result of the investigation other deficiencies were identified at F609 and F689. The survey resulted in an Immediate Jeopardy (IJ) and substandard quality of care at F689 related to the facility's failure to ensure safe smoking practices, with immediate risk to resident health and safety. The IJ began on 7/11/19, at 2:07 p.m. Facility administration were notified by survey staff on 7/11/19, at 4:24 p.m. The IJ was removed on 7/12/19, at 3:34 p.m. however, non-compliance remained at an isolated scope and severity which indicated no actual harm with potential for more than minimal harm (Level D). 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	F 000		

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

Electronically Signed | 08/15/2019

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 000	Continued From page 1 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 will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 609		8/28/19

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F 609	Continued From page 2 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report witnessed potential sexual abuse between 2 of 2 resident (R9 and R10) observed undressed together in bed and had severe cognitive impairment. Findings include: R9's admission Minimum Data Set (MDS) dated 5/14/19, identified R9 had severe cognitive impairment and had no behaviors. R1 did not require any mobility devices and was independent with transfers and locomotion on and off the unit. Diagnoses included dementia and traumatic brain injury. R9's undated facesheet did not identify any family or responsible party. R9's medical provider progress note dated 7/11/19, identified R9 was not her own responsible party and updated the social worker. R9's progress note dated 7/13/19, at 1:18 a.m identified R9 was observed in another male resident room partially undressed and sitting in his bed. Both residents were separated and monitored the rest of the night. R9 continued to walk around the unit with no issues. No other concerns the rest of the shift. "Resident is her own responsible party." R10's quarterly MDS dated 6/1/19, identified R10 had severe cognitive impairment with behaviors of wandering 1 to 3 days. R10 did not require any mobility devises and required supervision and	F 609	R9 and R10 allegations were reported to Jennifer Bahr, MDH Nursing Evaluator, while she was in the facility and investigation initiated. Current residents have the potential to be affected by the alleged deficiency. Re-educated the Administrator, Assistant Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, and Nursing Educator on the new protocol for reporting and investigating allegations of abuse. Administrator or designee will audit self-reports for proper reporting/timeliness weekly x 4, then, monthly x 3. Administrator or designee will monitor weekly for compliance. Results of audits will be forwarded to the QAPI committee for continued quality improvement and compliance x 3 months.	

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F 609	Continued From page 3	F 609		

oversight with transfers and locomotion on and off the unit. A diagnosis of Alzheimer's disease was identified.

R10's capacity to consent assessment dated 3/5/19, identified although R10 had severe cognition he was able to consent to sexual acts. Family were in agreement.

R10's progress note dated 7/13/19, at 1:16 p.m. R10 was observed with another female resident in his room partially undressed sitting in his bed. Both residents were separated and closely monitored the rest of the shift. No other concerns rest of the shift. attempted to contact responsible party for update, no answer left voicemail requesting call back

During interview on 7/17/19, at 7:23 a.m. registered nurse (RN)-A stated on 7/13/19 he received a call from the dementia unit that during rounds two nursing assistants walked into R10's room and R9 and R10 were partially undressed, they were separated and they monitored them closely the rest of the night. RN-A did not ask further detail of what partially undressed meant, but thought both R9's and R10's pants were down. Because of the potential for sexual abuse RN-A called the director of nursing (DON) right away. She asked me to call the responsible parties and she would notify the administrator. RN-A did not know any further information.

During interview on 7/17/19, at 10:18 a.m. DON stated she received a call on 7/13/19, from RN-A she was told staff had found R9 in R10's bed with their clothes off and the staff separated them. I asked him to call the responsible parties and then I notified the administrator. The administrator told

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F 609	Continued From page 4 me R9 was her own responsible party and didn't think it was an incident that needed to be reported to the SA and to instruct the nurse to do basic charting and keep the residents separated. The facility was in the process for filing for guardianship of R9, because she had no family involvement. During interview on 7/17/19, at 11:18 p.m. the administrator stated he was notified immediately of the incident as he currently made the decisions on what to report to the SA. He was told R10 was on top of R9 in R10's bed. I was told she was her own responsible party, and did not know she had such severe cognitive impairment. In hind sight the incident should have been reported to the SA because of their cognition and not knowing their abilities to consent to sexual acts. The facility was in process of an internal investigation and had determined R9 was able to consent to sexual acts. The facility policy Reporting Abuse to Management dated 11/17, defined sexual abuse as "non-consensual sexual contact of any type with a resident." identified any suspected or substantiated incident of abuse would be reported to the administrator and SA within 2 hours of the suspicion.	F 609		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		8/28/19

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F 689	Continued From page 5 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 smoking interventions assessed for safety were implemented for 1 of 3 residents (R1) who was observed to smoke with oxygen on. This resulted in an immediate jeopardy (IJ) situation, which resulted in substandard quality of care for R1, who remained at high risk for injury related to smoking with oxygen. The IJ began on 7/11/19, at 2:07 p.m. when it was identified R1 was smoking unsupervised while wearing oxygen, placing R1 at risk . Although, facility staff had knowledge of previous unsafe smoking events and had been assessed to need supervision with smoking, the care plan was not updated to identify this restriction and the facility was not providing consistent supervision for R1 while smoking. On 7/11/19, at 4:24 p.m. the director of nursing (DON) and administrator were notified of the IJ for R1. The IJ was removed on 7/12/19, at 3:34 p.m., however, non-compliance remained at an isolated scope and severity which indicated no actual harm with potential for more than minimal harm (Level D). Findings include: R1's quarterly Minimum Data Set (MDS) dated 4/27/19, identified R1 had intact cognition and required supervision with locomotion on and off the unit. R1 had no impairments to her upper extremities. Diagnoses included heart failure, anxiety and depression and was receiving oxygen therapy.	F 689	Resident R1 was re-assessed and identified to need continuous 1:1 supervision until discharge related to multiple unsafe smoking violations. R1 family was educated on not obtaining and providing R1 with smoking materials. R1's care plan was updated to include smoking safety interventions and staff were updated. Other residents identified to smoke and utilize oxygen were re-assessed with the new assessment and ensured care plans were current. Staff were educated on shutting oxygen off, removing tubing and tank, if residents were witnessed to smoke with oxygen on and then have the resident extinguish the cigarette immediately and bring the resident to the floor nurse for an immediate assessment. Books were placed on units identifying smokers and their current care plans. The smoking violation policy was reviewed and updated to reflect consequences for smoking violations. Supervision of smoking area audits will be completed weekly x 4, then, monthly x 3 by the Administrator and/or designee.	

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F 689	Continued From page 6 During observation on 7/11/19, at 2:07 p.m. R1 was seated in her wheelchair alone next to the the front entrance. R1 was smoking a cigarette in her left hand and had a nasal cannula on. R1's portable liquid oxygen tank was on, at 2.5 liters (L). The potable liquid oxygen tank had visable condensation coming from the bottom vents on the tank. At 2:08 p.m. the surveyor alerted unidentified staff inside the building that R1 was smoking outside the front entrance with oxygen on. Nursing assistant (NA)-A walked outside shut off R1's oxygen off and walked back into the facility. NA-A did not remove the oxygen or nasal cannula tubing from R1. R1 continued to smoke the cigarette. NA-A stated she did not know who the resident was or what R1's smoking care plan directed. NA-A stated R2 was smoking and R1's oxygen was on 2.5 L and it was dangerous to smoke with oxygen on. At 2:10 p.m. R1 put out her cigarette and wheeled herself back into the facility. The front desk receptionist (FDR) identified R1 and had alerted the facility staff R1 was outside smoking with her oxygen on. FDR stated she did not see her smoking outside or would have intervened. R1 always wore oxygen and smoked frequently throughout the day. Residents were not allowed to smoke in the front of the building near entrances or with oxygen on. FDR was not instructed by facility staff to monitor for unsafe smoking practices by residents. FDR was not aware where R1 left her oxygen when going out to smoke. At 2:12 p.m. the administrator stated R1 was	F 689	Administrator and/or designee will monitor for compliance weekly. Results of the audits will be forwarded to the QAPI committee for continued quality improvement and compliance.	

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being re-assessed for safe smoking and would educate R1 on the safety risks to herself and others smoking with oxygen poses.

At 2:30 p.m. the DON stated smoking with oxygen was not allowed as oxygen was very flammable. Staff had been storing R1's cigarettes and lighters on the medication cart because she had several previous smoking violation and had been on and off smoking supervision. The DON was not aware how R1 had received the cigarettes and started an investigation. The DON stated R1 would be immediately placed on supervised smoking.

R1's physician orders initiated 5/27/18, identified R1 was to use oxygen 2.5 L continuously.

R1's care plan initiated 10/27/17, identified R1 had a potential for a smoking related injury. R1 refused to sign the facility smoking policy; however, verbalized understanding of the policy. Interventions included: 10/31/17, educated R1 on not smoking when wearing oxygen; 12/4/17, smoking assessment to be completed quarterly and as needed; 4/9/19, R1 aware of smoking rules and provided contract; 6/11/19, smoking materials would be kept at the nursing station and the resident would bring them back to the nurse after utilizing them. The care plan did not address R1's oxygen use, who was responsible to remove it or where the oxygen would be stored while out smoking.

R1's smoking contract dated 10/27/17, identified the following: R1 would smoke in designated areas only; agree to a smoking evaluation on admission, quarterly and as needed, if nursing deemed resident unable to smoke safely then

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smoking activity would be supervised; if assessed to require supervision with smoking, smoking would be supervised at 7:00 a.m., 9:00 a.m., 11:00 a.m., 1:00 p.m. 3:00 p.m., 7:00 p.m. and 9:00 p.m.; if assessed to require supervision, supervision may be competed by a initiator after training; if assessed to require supervision all smoking material would be secured by staff; if using oxygen resident agrees to remove oxygen and store with staff while smoking; the facility did not allow resident to give any smoking materials to other residents; failure to comply with the smoking contract would result in the removal of smoking privileges. R1 refused to sign the smoking contract. The smoking contract did not identify if R1 was an independent or supervised smoker.

R1's smoking violations identified the following:

- 7/12/18, R1 was found smoking in her room on 7/11/18 and in the room next door.

- 7/14/18, R1 was observed on 7/13/18, smoking with portable oxygen tank on in the designated smoking area.

- 9/18/19, R1 violated the facility smoking policy on 9/14/18; however, did not identify what the smoking violation was.

- 12/5/18, R1 violated the facility smoking policy on 12/2/18; however, did not identify what the smoking violation was.

- 1/5/19, R1 was smoking in resident bedroom.

R1's progress notes from 1/4/19, through 7/11/19,

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F 689	Continued From page 9 identified the following: - 1/4/19, social services and nurse manger attempted to meet with R1 to discuss a 30 day discharge notice due to receiving multiple smoking violations. R1 was sleeping. - 1/5/19, smoke could be smelled from R1's bathroom. R1 had both doors to the bathroom locked and could be heard "spraying" then opened the door. R1 had her oxygen on R1 denied smoking. Safety risks of smoking in the building with oxygen were explained. Later in the day strong cigarette smoke could be smelled from residents bathroom again. R1 denied having smoking materials and denied smoking in her bathroom. Room and bathroom smelled strongly of cigarette smoke and cigarettes had been extinguished under the bathroom sink. A search was conducted and two boxes of cigarettes and two lighters were found. The supervisor was notified. - 1/8/19, social services and nurse manager spoke with resident and issued her a smoking violation from 1/5/19. R1 refused to sign the violation. Social services explained a 30 day discharge notice was being issued because of the repeated violations of the smoking policy and it was "endangering" R1 and others in the facility. Assistance with alternative placement would be completed. - 1/10/19, R1 was smoking in her bathroom. - 1/13/19, R1 was found smoking in her room with her oxygen on. When staff tried to redirect R1 she stated "I don't care, I just want to die." Updated supervisors. Cigarettes were collected	F 689		

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from the room and placed on 1:1 supervision for suicidal ideation.

- 1/16/19, social services and nurse manager went over smoking contract with R1 and highlighted the supervised smoking section as R1 "was now considered a supervised smoker." It meant R1 could only go smoke during supervised smoking times, and must give her smoking materials to nursing immediately upon returning to the unit.

- 4/4/19, R1 awoke at 11:00 p.m. and had been going back and forth fro the smoking area unit 4:00 a.m. The note did not identify R1 was supervised while smoking.

- 4/5/19, R1 awoke at 3:30 a.m. and went out to smoke. The note did not identify if staff supervised R1 while she smoked.

- 5/30/18, R1 had gone outside to smoke three times. The note did not identify if R1 was supervised while she smoked.

- 6/11/19, resident restricted with smoking because she was caught smoking with her oxygen on. R1 should be monitored at all times while smoking with no cigarettes or lighters in her possession.

- 6/12/19, R1 had been awake most of the night going out to smoke. The note did not identify if R1 was supervised while she smoked.

- 6/22/19 R1 had some mild confusion. Went to the smoking area one time and able to make it back to bed without concerns. The note did not identify if R1 was supervised while she smoked.

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- 6/23/19, R1 went outside to smoke one time during the shift. The note did not identify if R1 was supervised while she smoked.

- 6/27/19, R1 had a fall in the smoking area. The note identified R1 was previously supervised in the smoking area; however, was not compliant with supervision. The note did not address steps to ensure safe smoking.

R1's most recent Smoking Evaluation dated 6/12/19, identified R1 wanted to smoke during her stay. R1 did not have any cognitive loss, vision or dexterity issues. R1 smoked mornings, afternoons and nights. R1 could light her own cigarette and required supervision while smoking. R1 was safe to smoke with limitations and community rules had been supplied. The care plan was updated. The smoking assessment did not identify R1's use of oxygen or her history of unsafe smoking practices.

During interview on 7/12/19, at 8:55 a.m. the DON stated the facility would be revising their smoking violation policy as residents were receiving smoking violations without consequences. R1 obtained cigarettes from her family, which were not turned into the facility to monitor and that was how R1 ended up outside smoking. The DON was not aware R1 was supposed to be supervised following a smoking assessment dated 6/12/19, following a smoking violation and her care plan was not updated.

The facility Smoking policy dated 11/16, identified any smoking restrictions and concerns would be noted on the care plan and all personnel responsible for the resident would be alerted to

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the issues. Any resident with restricted smoking privileges, requiring monitoring would have direct supervision of a staff person at all times.

The facility Oxygen Administration policy dated 10/10, identified all potentially flammable items including smoking articles would not be in the area oxygen was administered.

The IJ that began on 7/11/19, was removed on 7/12/19, at 3:34 p.m. after the facility successfully implemented a removal plan through interviews and document review, which included the following:

- The facility updated their smoking assessment to include oxygen use.

- R1 was re-assessed and identified to need continuous 1:1 supervision until discharge related to multiple unsafe smoking violations.

- Family was educated on not obtaining and proving R1 with smoking materials.

- R1's care plan was updated to include smoking safety interventions and staff were updated.

- Staff were educated on shutting oxygen off, removing the tubing and tank, if residents were witnessed to smoke with oxygen on and then have the resident extinguish the cigarette immediately and bring the resident to the floor nurse for an immediate assessment.

- Books were placed on units identifying smokers and their current care plans.

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F 689	Continued From page 13 - Other residents identified to smoke and utilize oxygen were re-assessed with the new assessment and ensured care plans were current. - The smoking violation policy was reviewed and updated to reflect consequences for smoking violations.	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.	F 690		8/28/19

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F 690	Continued From page 14 §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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure catheter care was provided in a manner to prevent infections for 1 of 3 residents (R2) who was reviewed for catheter care. Findings include: R2's quarterly Minimum data Set (MDS) dated 4/26/19, identified R2 was cognitively intact. R2 had an indwelling catheter with a diagnosis of neurogenic bladder. R2's physician orders signed 6/24/19, identified an order for a foley catheter 16 french (F) 100 with cubic centimeter (cc) balloon for neurogenic bladder. Further, the order identified to change the catheter and bag as needed for signs and symptoms of infection, obstruction or when the closed unit had been compromised. R2's progress note dated 7/9/19, identified R2 had been admitted to the hospital for pneumonia. On 7/12/19, at 12:15 p.m. R2 was seated in her wheelchair with a covered foley catheter bag draining yellow urine. R2 stated the nursing assistants and herself empty the catheter. She was not sure how often the catheter was changed, but usually had it done at the hospital.	F 690	R2 has been discharged from the facility. Current residents with catheters have the potential to be affected by this alleged deficiency. Current nursing staff were re-educated on the indwelling urinary catheter care policy and emptying a urinary drainage bag policy. Catheter care audits of 4 random residents will be performed weekly x 4, then monthly x 3. DON and/or designee will perform the audits. Results of the audits will be forwarded to the QAPI committee for continued quality improvement and compliance. DON or designee will monitor for compliance weekly.	

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She had just returned from the hospital where they put a new catheter in and put on a new catheter bag. She was hospitalized on 7/9/19, with pneumonia, but was sent to the hospital with her catheter bag leaking and a clear plastic garbage bag had been tied around the catheter bag. An unidentified nursing assistant had but the plastic bag around the leaking catheter bag two days prior to going to the hospital. The nurses replaced her catheter bag on a weekly basis.

During interview on 7/15/19, at 12:55 p.m. nursing assistant (NA)-B stated she frequently took care of R2. The nursing assistants emptied the catheter bag every shift if R2 needed help with it. NA-B had overheard other staff talking about R2 having a hole in her catheter bag and someone had tied a clear garbage bag around it to prevent it from leaking; however, did not see it. If a residents catheter bag was leaking it should be reported to the nurse, so they could change the bag out.

During interview on 7/15/19, at 1:09 p.m. NA-C stated the nursing assistants do not change the catheter bags, the nurses change the bags. The nursing assistants help with emptying the catheter bag every shift and as needed. NA-A stated she saw R2 on 7/9/19, prior to going to the hospital. R2 was lying in bed and her catheter bag had a a hole in it and it had a clear plastic bag tied around it to collect the urine. NA-C stated she reported it to the nurse.

During interview on 1:17 p.m. licensed practical nurse (LPN)-A stated catheter bags were replaced if they were dirty or not intact. LPN-A had replaced R2's catheter bag the day before because it was leaking. The floor went through a

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lot of catheter supplies and on the weekend if they run out they need to contact the nursing supervisor to get more catheter supplies from the central supply closet. It was possible someone did not contact the nursing supervisor to get more supplies to change the catheter bag over the weekend. It was an infection control issue to not have a closed system catheter intact.

During observation on 7/15/19, at 1:35 p.m. NA-B washed her hands and put on gloves obtained an urinal from R2's bathroom and placed it directly on the floor without a barrier between the urinal and the floor. NA-B then opened the catheter and drained the urine into the urinal. NA-B then closed the catheter opening and secured it without cleansing with an alcohol wipe after emptying the catheter bag. NA-B then emptied the urinal in the toilet, removed her gloves and washed her hands.

During interview on 7/15/19, at 2:00 p.m. NA-B stated she aware she should cleanse the opening of the catheter bag with alcohol prior to clamping and securing the catheter opening; however, was not aware where the supplies were kept.

During interview on 2:25 p.m. registered nurse (RN)-B stated anytime a catheter or catheter bag needed to be changed and there were no supplies on the floor the nursing supervisor needed to be contacted to obtain the supplies from the central supply room. Staff were trained to use a barrier between the floor and urine collection device as well as use alcohol wipes on the catheter opening after emptying the catheter. Staff should ask for supply location if they did not know where to find the supplies. Not following protocol increased the residents chance of

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F 690	Continued From page 17 obtaining an urinary infection. During interview, via telephone, on 7/15/19, at 2:45 p.m. the hospital social worker stated R2 was admitted to the hospital on 7/9/19, with a soiled catheter. The catheter bag had a hole in it and it also had a clear plastic bag tied around the catheter bag, with urine in both the catheter bag and clear plastic bag. The hospital staff placed a new catheter and catheter bag. The facility policy Indwelling Urinary Catheter dated 11/17, identified if there was a break in aseptic technique, disconnection or leakage occurred, the staff were directed to replace the catheter and collecting system. The facility policy Emptying a urinary Drainage Bag dated 10/10, directed staff to place a paper towel on the floor beneath the drainage bag, position the measuring container under the drainage bag. After emptying the catheter, wipe the drain with an alcohol sponge or swab. replace the drain tube back into its holder.	F 690		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.	F 740		8/28/19

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F 740	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review , the facility failed to ensure psychology interventions were implemented for 1 of 3 residents (R9) who had increased behaviors and was seeing a psychologist. Findings include: R9's admission Minimum Data Set (MDS) dated 5/14/19, identified R9 had severe cognitive impairment and had no behaviors. R1 did not require any mobility devices and was independent with transfers and locomotion on and off the unit. Diagnoses included dementia and traumatic brain injury. R9's care plan revised 6/20/19, identified R9 had the potential to demonstrate physical behaviors related to anger, history of harm to others and poor impulse control. Interventions included: analyze key times, places, circumstances, triggers, and what de-escalates behaviors; assess and anticipate resident needs; provide physical and verbal cues to alleviate anxiety; evaluate side effects of medication; modify environment; monitor and report to medical doctor any danger to self or others; psychiatric consult as indicated and when the resident becomes agitated intervene before agitation escalates, guide away from distress, engage calmly in conversation, if response is aggressive walked away and reproach later. The care plan also identified R9 had or had the potential for mental or psychosocial adjustment disorder related to adjustment to the facility. Interventions included: monitor, document and report decreased social interaction, increased	F 740	R9 psychology interventions were implemented and care plan updated. Current residents utilizing ACP (in house psychology) have the potential to be affected by this alleged deficiency. Re-educated social services on the protocol for addressing ACP recommendations/interventions. Administrator and/or designee will audit 5 random resident's care plans to ensure ACP recommendations/interventions are completed weekly x 4, then, monthly x 3. Administrator and/or designee will monitor for compliance weekly. Results of the audits will be forwarded to the QAPI committee for continued quality improvement and compliance.	

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withdrawal, anger and depressive symptoms; refer to medical doctor , neurologist, psychologist as needed and administer medications as ordered.

R9's progress notes identified the following:

- 5/16/19, nursing assistant reported on 5/15/19, at about 7:30 a.m. R9 was observed with her hands around another residents neck in the hallway. Staff member reported both residents were having a verbal altercation prior to the incident. resident was observed throughout the day yelling and pacing the unit.

- 5/31/19, R9 stated stated to a nursing assistant "I want to kill someone". R9 was hearing a noise outside the bedroom window that was disturbing R9. Nurse supervisor was updated.

- 6/4/19, therapeutic recreation reviewed resident. She was social with staff and peers. R9 enjoyed walking around the unit and engaging with peers. R9 had occasionally shown aggressive behaviors towards others and was currently on 1:1 supervision at all times. R9 typically declined activity interventions but would wander in and out of groups at her own leisure.

- 6/9/19, R9 continued on the 1:1 supervision and had been wandering into other residents rooms, was agitated and angry at staff resisting redirection.

- 6/14/19, R9 was agitated and confused and was a threat to herself and others. R9 was using abusive and inappropriate language on staff. R9 was banging doors, entering others rooms, throwing coffee cups and personal clothing at

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F 740	Continued From page 20 staff. Was transferred to the emergency room for evaluation. - 6/19/19, At the beginning of the shift R9 was agitated and aggressive. R9 was standing by the elevator trying to get on the elevator using inappropriate words to staff when attempting to calm R9 down. R9 stated "I want to go home, why are you holding me here against my will." Supervisor was notified. - 6/19/19, R9 was moved to the secured unit due to elopement risk and past history of trying to attack another resident. - 6/19/19, R9 was getting agitated due to the noise on the unit and was asking for a gun to shoot someone. R9 also expressed she would choke anyone that came around her. She had a history of attacking peers. - 6/19/19, R9 continued to yell most of the shift. R9 requested to leave the unit and if she was not allowed to leave she would "kill someone." Staff attempted to redirect R9 but refused and was difficult to monitor. - 6/21/19, R9 had behaviors twice during the shift. She hit and emptied her tray on the floor in the dining room. She started screaming and stated "she has to go home and that her care is parked outside." resident was not redirectable for two hours during the evening shift. - 6/28/19, R9 threw one of her shoes at 9:30 p.m. at the nurses desk table and hit one of the charting tablets, breaking the front screen. R9 was redirected to watch television.	F 740		

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	245183	A. BUILDING _____ B. WING _____	C 07/17/2019

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F 740	Continued From page 21	F 740		

- 7/6/19, R9 threw a drink at one of the residents on the unit but missed. Staff tried to redirect the resident but she became combative and started to scream "I don't listen to no one." No one was injured and resident was being monitored. Supervisor was notified.

- 7/11/19, R9 was screaming at another resident to stop singing loud in the dining room. She walked up to the resident before staff could stop her she poured a half cup of cold coffee on the resident head. Staff removed her and would continue to monitor her.

R9's psychology notes identified the following:

- 6/18/19, psychology was referred for clinical evaluation for strategies to manage behaviors secondary to medical and mental health. R9 was not an accurate reported, but stated her hobbies were fishing, hinting, gardening, watching television and listening to the radio. There was no known chemical dependency history. R9 was friendly with moderate impaired short and long term memory. She had poor judgement. On 5/15/19, R9 had a verbal altercation that resulted in R9 placing her hands around the other residents neck. On 6/14/19, R9 was disruptive, physically and verbally aggressive. She was threatening staff and her table mate. She was pacing, anxious and feared that she would be locked up. She was throwing cups and clothing and threatening to kill staff.

Recommendations included: a private room; a television in her room; R9 enjoyed cats she may enjoy cat magazines and a stuffed cat. A neuropsychological evaluation was recommended to help determine if R9 was

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capable of making her own personal and financial decisions; R9 stated she was Irish and may enjoy Irish theme items and activities; behaviors maybe related to adjustment. The goal would be to orientate her to the new environment and routine to help her feel safe and comfortable; medical reasons should be ruled out; it would be helpful for regular staff on the unit to make a point and check in with R9 regularly to help build rapport; personalize her room. recommendation related to aggressive behavior were as follows; staff are encouraged to be proactive in trying to prevent opportunities for aggression towards others by considering proximity to others at meals, during activities, in the hall and when moving throughout the unit and she may benefit from staff moving slowly, speaking in a calming voice and reproaching resident as needed when increased agitation was noted. rather than trying to complete cares when she was agitated. R9's care plan was not updated to reflect these interventions.

-6/25/19, psychology recommended staff to assist R9 with letting it go when she expressed frustration and agitation. To approach R9 from the front wit ha smile and kindness. Keep R9 a safe distance from others when agitated and R9 may benefit from personalization of her room, which may include hanging pictures of cats as cats make her happy. R9's care plan was not updated with these recommendations.

- 7/9/19, psychology recommended staff to assist R9 with letting it go when she expressed frustration and agitation. Allow R9 to sit outside when she appeared agitated for a distraction. Staff to remind R9 to use gratitude each day. When R9 appeared agitated it was best to

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approach from the front with a smile and validate her feelings. R9's care plan was not updated to reflect these recommendations.

On 7/16/19, at 2:56 p.m. R9 walked down to her room independently without any mobility device. R9 had a private room at the end of the hallway furthest from the nursing station, on the secured dementia unit. R9 had a television in her room. The walls were bare. R9 had a stuffed cat on her bed that she picked up and stated she liked her cat but didn't know what to call the cat today. R9 was not consistent in her conversation, but stated sometimes you need to scare people to get them to do what you wanted them to do.

During interview on 7/16/19, at 3:41 p.m. NA-D stated R9 was on 15 minute checks because she tried to hit someone. R9 was pretty calm most of the time and didn't know of any specific behavior interventions for R9.

During interview on 7/16/19, at 8:15 a.m. NA-E stated R9 was on 15 minute checks. After R9 spilled cold coffee on another resident the facility moved the microwave and coffee make behind the nursing station and were monitoring R9 when she had coffee. R9 can be very calm at times and other times screamed and was more aggressive. The other residents had not reported or acted afraid of R9. NA-E stated it can get loud on the secured unit and that made R9 more agitated.

During interview on 7/16/19, at 8:16 a.m. NA-F stated R9 was on 15 minute checks for more supervision when it was loud she got agitated NA-F was not aware of any specific behavior interventions for R9.

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During interview on 7/16/19, at 8:58 a.m. registered nurse (RN)-C stated prior to R9 moving to the secured unit she was on 1:1 supervision related to aggressive behavior and elopement attempts. She was moved to the secured unit for closer supervision and was placed on 15 minute checks. There was not an assessment completed on her behaviors to warrant the discontinuation of the 1:1 supervision, but felt the move to the secured unit eliminated the need for the 1:1. RN-C stated she was not aware of the psychology recommendations and did not know if she had an appointment for neuropsychological scheduled. The staff were responsible to separate and redirect R9 when she was agitated.

During interview on 7/16/19, at 9:11 a.m. RN-D stated moving R9 to the secured unit limited the dynamic and therefore the need for 1:1 supervision; however, there was not a comprehensive assessment. R9 was seen by psychology to help manage behaviors. RN-D was not aware of an upcoming appointment for neuropsychological as suggested by the psychologist. RN-D was not aware of the specific interventions recommended to the psychologist to decrease aggressive behaviors. the social worker received the psychology notes then the team would review them and implement appropriate interventions.

During interview on 7/16/19, at 9:43 a.m. licensed social worker (LSW)-A stated a few months back she stopped getting all the psychologist notes with recommendations. They were inadvertently sent to medical records where they were scanned into the chart without anyone reviewing them. She just started receiving them this past week again

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F 740	Continued From page 25 and needed to review all previous notes to ensure interventions were implemented. During interview on 7/16/19, at 10:15 a.m. the health unit coordinator stated she had not scheduled an appointment for neuropsychological for R9 because she was not aware. During interview on 7/16/19, at 10:18 a.m. director of nursing (DON) stated she was just made aware R9's psychology notes had not been reviewed and interventions had not been implemented. Staff were in the process of scheduling her a neuropsychological appointment which was missed. It was important to follow through with behavioral interventions to prevent harm to herself and others. A policy on behavioral interventions was requested and not received.	F 740		

Electronically Delivered August 6, 2019

Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, MN 55428

Re: State Nursing Home Licensing Orders - Complaint Number H5183195C, H5183196C, H5183197C, and H5183198C

Dear Administrator:

A complaint investigation was completed on July 17, 2019. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations 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 of the Minnesota Department of Health.

To assist in complying with the licensing 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 violation. 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 violation within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing 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 after the statement, "This Rule is not met as evidenced by." Following investigator's 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.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Susie Haben, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301
Email: susie.haben@state.mn.us
Phone: 320-223-7356
Fax: 320-223-7348

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request 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.

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

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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 7/11/19, through 7/17/19 an abbreviated survey was conducted to determine compliance with state licensure. The following complaints were investigated: H5183195C , H5183196C, H5183197C and H5183198C. The following correction order(s) are issued.	2 000		

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2 000	Continued From page 1 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. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS	2 000		

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2 000	Continued From page 2 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		
2 830	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 ensure smoking interventions assessed for safety were implemented for 1 of 3 residents (R1) who was observed to smoke with oxygen on. This resulted in an immediate jeopardy (IJ) situation, which resulted in substandard quality of care for R1, who remained at high risk for injury related to smoking with oxygen. The IJ began on 7/11/19, at 2:07 p.m. when it was identified R1 was smoking unsupervised while wearing oxygen, placing R1 at risk .	2 830	Resident R1 was re-assessed and identified to need continuous 1:1 supervision until discharge related to multiple unsafe smoking violations. R1 family was educated on not obtaining and providing R1 with smoking materials. R1's care plan was updated to include smoking safety interventions and staff were updated. Other residents identified to smoke and	8/28/19

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2 830	Continued From page 3 Although, facility staff had knowledge of previous unsafe smoking events and had been assessed to need supervision with smoking, the care plan was not updated to identify this restriction and the facility was not providing consistent supervision for R1 while smoking. On 7/11/19, at 4:24 p.m. the director of nursing (DON) and administrator were notified of the IJ for R1. The IJ was removed on 7/12/19, at 3:34 p.m., however, non-compliance remained at an isolated scope and severity which indicated no actual harm with potential for more than minimal harm (Level D). Findings include: R1's quarterly Minimum Data Set (MDS) dated 4/27/19, identified R1 had intact cognition and required supervision with locomotion on and off the unit. R1 had no impairments to her upper extremities. Diagnoses included heart failure, anxiety and depression and was receiving oxygen therapy. During observation on 7/11/19, at 2:07 p.m. R1 was seated in her wheelchair alone next to the the front entrance. R1 was smoking a cigarette in her left hand and had a nasal cannula on. R1's portable liquid oxygen tank was on, at 2.5 liters (L). The potable liquid oxygen tank had visable condensation coming from the bottom vents on the tank. At 2:08 p.m. the surveyor alerted unidentified staff inside the building that R1 was smoking outside the front entrance with oxygen on. Nursing assistant (NA)-A walked outside shut off R1's oxygen off and walked back into the facility. NA-A did not remove the oxygen or nasal cannula tubing from R1. R1 continued to smoke the cigarette. NA-A stated she did not know who the	2 830	utilize oxygen were re-assessed with the new assessment and ensured care plans were current. Staff were educated on shutting oxygen off, removing tubing and tank, if residents were witnessed to smoke with oxygen on and then have the resident extinguish the cigarette immediately and bring the resident to the floor nurse for an immediate assessment. Books were placed on units identifying smokers and their current care plans. The smoking violation policy was reviewed and updated to reflect consequences for smoking violations. Supervision of smoking area audits will be completed weekly x 4, then, monthly x 3 by the Administrator and/or designee. Administrator and/or designee will monitor for compliance weekly. Results of the audits will be forwarded to the QAPI committee for continued quality improvement and compliance.	

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2 830	Continued From page 4 resident was or what R1's smoking care plan directed. NA-A stated R2 was smoking and R1's oxygen was on 2.5 L and it was dangerous to smoke with oxygen on. At 2:10 p.m. R1 put out her cigarette and wheeled herself back into the facility. The front desk receptionist (FDR) identified R1 and had alerted the facility staff R1 was outside smoking with her oxygen on. FDR stated she did not see her smoking outside or would have intervened. R1 always wore oxygen and smoked frequently throughout the day. Residents were not allowed to smoke in the front of the building near entrances or with oxygen on. FDR was not instructed by facility staff to monitor for unsafe smoking practices by residents. FDR was not aware where R1 left her oxygen when going out to smoke. At 2:12 p.m. the administrator stated R1 was being re-assessed for safe smoking and would educate R1 on the safety risks to herself and others smoking with oxygen poses. At 2:30 p.m. the DON stated smoking with oxygen was not allowed as oxygen was very flammable. Staff had been storing R1's cigarettes and lighters on the medication cart because she had several previous smoking violation and had been on and off smoking supervision. The DON was not aware how R1 had received the cigarettes and started an investigation. The DON stated R1 would be immediately placed on supervised smoking. R1's physician orders initiated 5/27/18, identified R1 was to use oxygen 2.5 L continuously. R1's care plan initiated 10/27/17, identified R1	2 830		

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2 830	Continued From page 5 had a potential for a smoking related injury. R1 refused to sign the facility smoking policy; however, verbalized understanding of the policy. Interventions included: 10/31/17, educated R1 on not smoking when wearing oxygen; 12/4/17, smoking assessment to be completed quarterly and as needed; 4/9/19, R1 aware of smoking rules and provided contract; 6/11/19, smoking materials would be kept at the nursing station and the resident would bring them back to the nurse after utilizing them. The care plan did not address R1's oxygen use, who was responsible to remove it or where the oxygen would be stored while out smoking. R1's smoking contract dated 10/27/17, identified the following: R1 would smoke in designated areas only; agree to a smoking evaluation on admission, quarterly and as needed, if nursing deemed resident unable to smoke safely then smoking activity would be supervised; if assessed to require supervision with smoking, smoking would be supervised at 7:00 a.m., 9:00 a.m., 11:00 a.m., 1:00 p.m. 3:00 p.m., 7:00 p.m. and 9:00 p.m.; if assessed to require supervision, supervision may be competed by a initiator after training; if assessed to require supervision all smoking material would be secured by staff; if using oxygen resident agrees to remove oxygen and store with staff while smoking; the facility did not allow resident to give any smoking materials to other residents; failure to comply with the smoking contract would result in the removal of smoking privileges. R1 refused to sign the smoking contract. The smoking contract did not identify if R1 was an independent or supervised smoker. R1's smoking violations identified the following:	2 830		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

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2 830	Continued From page 6 - 7/12/18, R1 was found smoking in her room on 7/11/18 and in the room next door. - 7/14/18, R1 was observed on 7/13/18, smoking with portable oxygen tank on in the designated smoking area. - 9/18/19, R1 violated the facility smoking policy on 9/14/18; however, did not identify what the smoking violation was. - 12/5/18, R1 violated the facility smoking policy on 12/2/18; however, did not identify what the smoking violation was. - 1/5/19, R1 was smoking in resident bedroom. R1's progress notes from 1/4/19, through 7/11/19, identified the following: - 1/4/19, social services and nurse manger attempted to meet with R1 to discuss a 30 day discharge notice due to receiving multiple smoking violations. R1 was sleeping. - 1/5/19, smoke could be smelled from R1's bathroom. R1 had both doors to the bathroom locked and could be heard "spraying" then opened the door. R1 had her oxygen on R1 denied smoking. Safety risks of smoking in the building with oxygen were explained. Later in the day strong cigarette smoke could be smelled from residents bathroom again. R1 denied having smoking materials and denied smoking in her bathroom. Room and bathroom smelled strongly of cigarette smoke and cigarettes had been extinguished under the bathroom sink. A search was conducted and two boxes of cigarettes and two lighters were found. The	2 830		

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2 830	Continued From page 7 supervisor was notified. - 1/8/19, social services and nurse manager spoke with resident and issued her a smoking violation from 1/5/19. R1 refused to sign the violation. Social services explained a 30 day discharge notice was being issued because of the repeated violations of the smoking policy and it was "endangering" R1 and others in the facility. Assistance with alternative placement would be completed. - 1/10/19, R1 was smoking in her bathroom. - 1/13/19, R1 was found smoking in her room with her oxygen on. When staff tried to redirect R1 she stated "I don't care, I just want to die." Updated supervisors. Cigarettes were collected from the room and placed on 1:1 supervision for suicidal ideation. - 1/16/19, social services and nurse manager went over smoking contract with R1 and highlighted the supervised smoking section as R1 "was now considered a supervised smoker." It meant R1 could only go smoke during supervised smoking times, and must give her smoking materials to nursing immediately upon returning to the unit. - 4/4/19, R1 awoke at 11:00 p.m. and had been going back and forth fro the smoking area unit 4:00 a.m. The note did not identify R1 was supervised while smoking. - 4/5/19, R1 awoke at 3:30 a.m. and went out to smoke. The note did not identify if staff supervised R1 while she smoked. - 5/30/18, R1 had gone outside to smoke three	2 830		

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2 830	Continued From page 8 times. The note did not identify if R1 was supervised while she smoked. - 6/11/19, resident restricted with smoking because she was caught smoking with her oxygen on. R1 should be monitored at all times while smoking with no cigarettes or lighters in her possession. - 6/12/19, R1 had been awake most of the night going out to smoke. The note did not identify if R1 was supervised while she smoked. - 6/22/19 R1 had some mild confusion. Went to the smoking area one time and able to make it back to bed without concerns. The note did not identify if R1 was supervised while she smoked. - 6/23/19, R1 went outside to smoke one time during the shift. The note did not identify if R1 was supervised while she smoked. - 6/27/19, R1 had a fall in the smoking area. The note identified R1 was previously supervised in the smoking area; however, was not compliant with supervision. The note did not address steps to ensure safe smoking. R1's most recent Smoking Evaluation dated 6/12/19, identified R1 wanted to smoke during her stay. R1 did not have any cognitive loss, vision or dexterity issues. R1 smoked mornings, afternoons and nights. R1 could light her own cigarette and required supervision while smoking. R1 was safe to smoke with limitations and community rules had been supplied. The care plan was updated. The smoking assessment did not identify R1's use of oxygen or her history of unsafe smoking practices.	2 830		

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2 830	Continued From page 9 During interview on 7/12/19, at 8:55 a.m. the DON stated the facility would be revising their smoking violation policy as residents were receiving smoking violations without consequences. R1 obtained cigarettes from her family, which were not turned into the facility to monitor and that was how R1 ended up outside smoking. The DON was not aware R1 was supposed to be supervised following a smoking assessment dated 6/12/19, following a smoking violation and her care plan was not updated. The facility Smoking policy dated 11/16, identified any smoking restrictions and concerns would be noted on the care plan and all personnel responsible for the resident would be alerted to the issues. Any resident with restricted smoking privileges, requiring monitoring would have direct supervision of a staff person at all times. The facility Oxygen Administration policy dated 10/10, identified all potentially flammable items including smoking articles would not be in the area oxygen was administered. The IJ that began on 7/11/19, was removed on 7/12/19, at 3:34 p.m. after the facility successfully implemented a removal plan through interviews and document review, which included the following: - The facility updated their smoking assessment to include oxygen use. - R1 was re-assessed and identified to need continuous 1:1 supervision until discharge related to multiple unsafe smoking violations. - Family was educated on not obtaining and proving R1 with smoking materials.	2 830		

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2 830	Continued From page 10 - R1's care plan was updated to include smoking safety interventions and staff were updated. - Staff were educated on shutting oxygen off, removing the tubing and tank, if residents were witnessed to smoke with oxygen on and then have the resident extinguish the cigarette immediately and bring the resident to the floor nurse for an immediate assessment. - Books were placed on units identifying smokers and their current care plans. - Other residents identified to smoke and utilize oxygen were re-assessed with the new assessment and ensured care plans were current. - The smoking violation policy was reviewed and updated to reflect consequences for smoking violations. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) and/or designee could review and/or develop policies and provide education for staff regarding smoking assessments and updating the care plans. In addition the DON/ designee could audit residents for proper smoking plans.The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 830		

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2 910	Continued From page 11	2 910		
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 ensure catheter care was provided in a manner to prevent infections for 1 of 3 residents (R2) who was reviewed for catheter care. Findings include: R2's quarterly Minimum data Set (MDS) dated 4/26/19, identified R2 was cognitively intact. R2 had an indwelling catheter with a diagnosis of neurogenic bladder. R2's physician orders signed 6/24/19, identified an order for a foley catheter 16 french (F) 100 with cubic centimeter (cc) balloon for neurogenic bladder. Further, the order identified to change	2 910	R2 has been discharged from the facility. Current residents with catheters have the potential to be affected by this alleged deficiency. Current nursing staff were re-educated on the indwelling urinary catheter care policy and emptying a urinary drainage bag policy. Catheter care audits of 4 random residents will be performed weekly x 4, then monthly x 3. DON and/or designee will perform the audits. Results of the audits will be forwarded to	8/28/19

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2 910	Continued From page 12 the catheter and bag as needed for signs and symptoms of infection, obstruction or when the closed unit had been compromised. R2's progress note dated 7/9/19, identified R2 had been admitted to the hospital for pneumonia. On 7/12/19, at 12:15 p.m. R2 was seated in her wheelchair with a covered foley catheter bag draining yellow urine. R2 stated the nursing assistants and herself empty the catheter. She was not sure how often the catheter was changed, but usually had it done at the hospital. She had just returned from the hospital where they put a new catheter in and put on a new catheter bag. She was hospitalized on 7/9/19, with pneumonia, but was sent to the hospital with her catheter bag leaking and a clear plastic garbage bag had been tied around the catheter bag. An unidentified nursing assistant had but the plastic bag around the leaking catheter bag two days prior to going to the hospital. The nurses replaced her catheter bag on a weekly basis. During interview on 7/15/19, at 12:55 p.m. nursing assistant (NA)-B stated she frequently took care of R2. The nursing assistants emptied the catheter bag every shift if R2 needed help with it. NA-B had overheard other staff talking about R2 having a hole in her catheter bag and someone had tied a clear garbage bag around it to prevent it from leaking; however, did not see it. If a residents catheter bag was leaking it should be reported to the nurse, so they could change the bag out. During interview on 7/15/19, at 1:09 p.m. NA-C stated the nursing assistants do not change the catheter bags, the nurses change the bags. The nursing assistants help with emptying the	2 910	the QAPI committee for continued quality improvement and compliance. DON or designee will monitor for compliance weekly.	

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2 910	Continued From page 13 catheter bag every shift and as needed. NA-A stated she saw R2 on 7/9/19, prior to going to the hospital. R2 was lying in bed and her catheter bag had a a hole in it and it had a clear plastic bag tied around it to collect the urine. NA-C stated she reported it to the nurse. During interview on 1:17 p.m. licensed practical nurse (LPN)-A stated catheter bags were replaced if they were dirty or not intact. LPN-A had replaced R2's catheter bag the day before because it was leaking. The floor went through a lot of catheter supplies and on the weekend if they run out they need to contact the nursing supervisor to get more catheter supplies from the central supply closet. It was possible someone did not contact the nursing supervisor to get more supplies to change the catheter bag over the weekend. It was an infection control issue to not have a closed system catheter intact. During observation on 7/15/19, at 1:35 p.m. NA-B washed her hands and put on gloves obtained an urinal from R2's bathroom and placed it directly on the floor without a barrier between the urinal and the floor. NA-B then opened the catheter and drained the urine into the urinal. NA-B then closed the catheter opening and secured it without cleansing with an alcohol wipe after emptying the catheter bag. NA-B then emptied the urinal in the toilet, removed her gloves and washed her hands. During interview on 7/15/19, at 2:00 p.m. NA-B stated she aware she should cleanse the opening of the catheter bag with alcohol prior to clamping and securing the catheter opening; however, was not aware where the supplies were kept. During interview on 2:25 p.m. registered nurse	2 910		

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2 910	Continued From page 14 (RN)-B stated anytime a catheter or catheter bag needed to be changed and there were no supplies on the floor the nursing supervisor needed to be contacted to obtain the supplies from the central supply room. Staff were trained to use a barrier between the floor and urine collection device as well as use alcohol wipes on the catheter opening after emptying the catheter. Staff should ask for supply location if they did not know where to find the supplies. Not following protocol increased the residents chance of obtaining an urinary infection. During interview, via telephone, on 7/15/19, at 2:45 p.m. the hospital social worker stated R2 was admitted to the hospital on 7/9/19, with a soiled catheter. The catheter bag had a hole in it and it also had a clear plastic bag tied around the catheter bag, with urine in both the catheter bag and clear plastic bag. The hospital staff placed a new catheter and catheter bag. The facility policy Indwelling Urinary Catheter dated 11/17, identified if there was a break in aseptic technique, disconnection or leakage occurred, the staff were directed to replace the catheter and collecting system. The facility policy Emptying a urinary Drainage Bag dated 10/10, directed staff to place a paper towel on the floor beneath the drainage bag, position the measuring container under the drainage bag. After emptying the catheter, wipe the drain with an alcohol sponge or swab. replace the drain tube back into its holder. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) and/or designee could review and/or develop policies and provide	2 910		

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2 910	Continued From page 15 education for staff regarding proper catheter care and where to obtain supplies. In addition the DON/ designee could audit residents for proper catheter care. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 910		