Electronically delivered
June 20, 2019

Administrator
Texas Terrace A Villa Center
7900 West 28th Street
Saint Louis Park, MN 55426

RE: Project Number H5187100C, H5187101C, H5187102C, H5187103C, H5187104C, H5187105C, H5187106C, and H5187107C

Dear Administrator:

On June 5, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Departments of Health, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the June 5, 2019 standard survey the Minnesota Department of Health, completed an investigation of complaint numbers H5187104C and H5187106C which were substantiated.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) , as evidenced by the electronically attached CMS-2567 whereby corrections are required. In addition, at the time of the June 5, 2019, abbreviated survey, the Minnesota Department of Health, completed an investigation of complaint number H5187100C, H5187101C, H5187102C, H5187103C, H5187105C, and H5187107C that were found to be unsubstantiated.

## OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is July 15, 2019.

## ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same

deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

## DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

## 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, if your ePoC for the respective deficiencies (if any) is acceptable.

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

## FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 5, 2019 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 5, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

## INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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.

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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245187 | A. BUILDING _____ B. WING _____ | C 06/05/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **TEXAS TERRACE A VILLA CENTER** | **7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426** |

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| F 000 | INITIAL COMMENTS<br><br>On 6/3/19-6/5/19, an unannounced abbreviated survey was completed at your facility to conduct a complaint investigation. Texas Terrace A Villa Center was found not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities<br><br>The following complaints were found to be substantiated:<br><br>H5187104C<br>H5187106C<br><br>The following complaints were found to be unsubstantiated:<br><br>H5187100C<br>H5187101C<br>H5187102C<br>H5187103C<br>H5187105C<br>H5187107C<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |

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

Electronically Signed | 06/26/2019

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 677 SS=D | ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide timely assistance with incontinence cares for 1 of 1 resident (R5) who was dependent on facility staff for incontinence cares.<br><br>Findings Include:<br><br>Review of R5's annual Minimum Data Set (MDS) dated 5/3/19, identified R5 had diagnoses which included dementia, diabetes and schizophrenia. The MDS identified R5 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, toileting and personal hygiene. The MDS identified R5 was always incontinent of urine and was not on a toileting program.<br><br>Review of R5's ADL Care Area Assessment (CAA) dated 5/3/19, identified R5 had both short and long term memory loss. The CAA identified R5 had moderate difficulty understanding others and had difficulty making himself understood. The CAA identified R5 was incontinent of urine, required extensive assistance with toileting and personal hygiene and would be checked and changed every two hours for incontinence.<br><br>R5's current bladder assessment dated 4/30/19, identified R5 was always incontinent of urine, | F 677 | The plan of correction is being submitted in compliance with specific regulatory requirements and preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the facts alleged or conclusions set forth on the statement of deficiencies. Please accept this plan of correction as the centers written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. Texas Terrace, a Villa Center respectfully submits this plan of correction and our allegation of compliance as of July 12, 2019.<br><br>F677<br>1. Resident #5 has had a new bladder assessment and toileting plan, includes incontinent care. Toileting and incontinence care is being provided per his care plan.<br><br>2. All residents requiring assistance with toileting and incontinence care are being toileted and incontinence care per plan of care.<br><br>3. Staff have been re-educated regarding toileting and providing incontinence care | 7/12/19 |

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| F 677 | Continued From page 2<br>wore a disposable incontinent brief. The bladder assessment identified R5 was dependent on nursing staff for incontinence cares and was on a routine check and change program.<br><br>Review of R5's current care plan revised, 5/20/19, revealed R5 was always incontinent of urine, wore an incontinence brief and required extensive assistance of two with checking and changing every two hours.<br><br>On 6/3/19, at 3:08 p.m. R5 was observed seated in a wheelchair in the common area, by the nurse's station. R5 wore gray sweatpants, tennis shoes and a t-shirt. R5's sweatpants had no visible wetness.<br><br>-at 4:35 p.m. R5 remained seated in a wheelchair in the common area with several other residents while an activity aid read to the group. R5's sweatpants had no visible wetness.<br><br>-at 5:11 p.m. R5 remained seated in a wheelchair in the common area, with several other residents. At that time, the activity aid stopped reading. R5 picked up a magazine and began to page through it. R5's sweatpants had a large wet spot over his groin.<br><br>-at 5:28 p.m. R5 wheeled himself towards his room, stopped and spoke with NA-A to ask what was for dinner. NA-A answered R5, looked down to his groin and stated R5 needed to be changed. NA-A proceeded to wheel R5 to his room. At that time, NA-A stated R5 had been incontinent of urine, which had soaked through his clothing. R5 wheeled himself in front of the television set, took hold of the remote control and turned on the television. | F 677 | per plan of care.<br><br>4. DON/Designee will audit 5 residents per week x 2 weeks, then 3 residents per week x 2 weeks, then 2 residents per week x1 week to ensure toileting plans and incontinence care are implemented. Results of audits will be reviewed in QAPI. | |

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| F 677 | Continued From page 3 | F 677 | | |

-at 5:30 p.m. registered nurse manager (NM)-A entered R5's room, wheeled R5 to the end of his bed, removed his footrests and R5 proceeded to reach out and hold the end of the bed and stood up. At that time, NM-A confirmed R5 had been incontinent of a large amount of urine, which had soaked through his incontinent brief, sweatpants and onto the towel covered seat of the wheelchair. NA-A assisted R5 to remove the urine saturated incontinent brief, cleanse, donne a clean incontinent brief, and put on a pair of shorts. NM-A removed the wet white towel from R5's wheelchair seat and applied a pressure relieving cushion. NM-A was not observed to cleanse the seat of R5's wheelchair. R5 was assisted to sit on the cushioned seat of the wheelchair, wheeled himself in front of the television and turned up the volume.

On 6/3/19, at 5:38 p.m. NM-A stated R5 was always incontinent of urine and would frequently have episodes of large amount of urine incontinence which would end up saturating the incontinent brief and saturate his clothing with urine. NM-A confirmed R5 was on a routine every two hour check and change program.

On 6/3/19, at 5:42 p.m. NA-A stated she had last checked and changed R5 at 2:30 that afternoon, and had thought another NA had assisted R5 to change his incontinent brief between 2:30 p.m. and 5:30 p.m. NA-A stated R5 was always incontinent of urine and wore an incontinent brief daily. NA-A stated R5 required extensive assistance with all of his ADL's and was checked and changed every two hours for incontinence. Further, NA-A indicated R5 would frequently soak through his incontinent brief and his clothing

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| F 677 | Continued From page 4<br>when he was incontinent of urine.<br><br>On 6/4/19, at 11:50 a.m. licensed practical nurse (LPN)-B stated R5 was totally dependent on staff for checking and changing every two hours. LPN-B stated at times R5 would refuse checking and changing and indicated R5 frequently would soil through his brief and onto his clothing.<br><br>On 6/4/19, at 11:54 a.m. during a follow up interview, NM-A stated R5 required "cares in pairs," due to combativeness with cares and a history of R5 reporting staff had hit him. NM-A stated R5 required assistance with checking and changing his incontinent brief every two hours. She stated R5 drank large amounts of fluids during the day and felt R5 soiled through his brief and clothing as a result of large fluid intake. NM-A confirmed R5's excessive fluid intake had not been identified as a factor of his incontinence. NM-A confirmed R5 routinely soaked through his disposable incontinent brief and had R5 had not been re-assessed for another type of incontinent product or changes in his toileting schedule.<br><br>On 6/5/19, at 9:37 a.m. the director of nursing (DON) stated she would expect R5's care plan to be followed and staff to offer checking and changing every two hours. The DON stated she would have expected R5's urinary incontinence to be re-assessed to ensure the incontinent product and frequency of checking and changing were appropriate for R5.<br><br>Review of a facility policy titled, Bowel and Bladder management dated 11/28/17, identified it was the facility's policy to ensure all residents were accurately and comprehensively assessed for urinary incontinence upon admission, quarterly | F 677 | | |

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| F 677 | Continued From page 5<br>and as needed. The policy revealed residents who had been assessed as having urinary incontinence would then be placed on a toileting program which included routine checking and changing. | F 677 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to comprehensively assess, implement interventions and monitor 1 of 3 residents (R9) at risk for elopement and had actual elopement occurrences in which staff had not been aware of.<br><br>Findings include:<br><br>R9's 14 day Prospective Payment System (PPS) Minimum Data Set (MDS) dated 4/19/19, indicated R9 had diagnoses which included anemia, high blood pressure and depression. R9's MDS further indicated he had moderate impaired cognition and required extensive assistance with bed mobility, transfers, dressing, toileting and personal hygiene. The MDS identified R9 had no behaviors and did not wander. | F 689 | F689<br><br>1. Resident #9 has had his elopement assessment updated and reviewed and his care plan interventions reviewed, updated and implemented.<br><br>2. All residents at risk for elopement have had their assessments, care plans and interventions reviewed.<br><br>3. Licensed staff have been re-educated about elopement assessments, care plans and implementation of care plans.<br><br>4. Don/Designees will audit 3 residents per week x2 weeks, then 2 residents per week x2 weeks, then 1 resident per week x2 weeks to ensure elopement assessments, care plans and | 7/12/19 |

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| F 689 | Continued From page 6<br>R9's admission Care Area Assessments (CAA) dated 4/23/19, indicated R9 had cognitive loss and had rejected care one time during the assessment reference period. The CAA further indicated R9 required extensive assistance with bed mobility, transfers, locomotion, dressing, toileting and personal hygiene. The CAA identified R9 was frequently incontinent of bladder and was at risk for falls. However, the CAA lacked documentation of analysis of wandering or elopement behavior.<br><br>R9's care plan revised on 5/30/19, indicated R9 had a behavior problem related to alcohol dementia with history of noncompliance with facility policy. R9 had behavior of going out with metro mobility to disapproved places by guardian and would return drunk to previous facility, had current alcohol abuse and was to have no access to alcohol. The care plan indicated R9 was at risk for elopement due to cognitive impairments and identified R9 had a history of calling transportation to leave the facility. The care plan instructed staff to be aware of R9's wander risk as well as distract R9 from wandering by offering pleasant diversions or activities. R9's care plan instructed staff to place a Wanderguard on his wrist and further indicated R9 was not to leave the facility without escort and guardian approval.<br><br>R9's Admission Assessment dated 4/8/19, indicated R9 was not at risk for elopement.<br><br>R9's Wander/Elopement Risk Evaluation dated 5/31/19, indicated R9 was at risk for wandering or elopement. The assessment indicated R9 was cognitively impaired, physically able to leave the building on his own in his wheelchair, and R9 had a history of leaving the unit or the facility. The | F 689 | interventions are appropriately implemented. Audit results will be reviewed at QAPI. | |

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| F 689 | Continued From page 7 | F 689 | | |

assessment indicated R9 had exhibited behavior of attempting to exit unit or facility, had a history of calling a cab or metro mobility, and had a guardian who did not want R9 to leave the facility without escort.

Review of the sign out log stored at the nurse's station revealed R9 left the facility on 4/9/19, 5/14/19, 5/16/19, 5/18/19, and 5/28/19, as verified by his signature each time. The form identified R9 went to Target on two different occasions and to the library on one occasion. The form had one entry which only indicated R9 went out of the facility. The form lacked documentation of an escort assisting R9 to safely go into the community. Further, the form lacked consistent documentation of the dates and times R9 returned to the facility. No further documentation of R9's leaving the facility was noted.

Review of R9's progress notes revealed the following:

- 4/9/19, guardian indicated R9 had a history of elopement and becoming drunk after consuming alcohol. The guardian further indicated R9 had the potential to elope again. The guardian requested a Wanderguard be placed and staff indicated they would discuss with R9 due to resident rights.

- 4/10/19, staff found two bottles of Vodka in R9's room and they were removed. R9 was reminded of the unauthorized substances policy and was informed a Wanderguard would be placed.

- 5/29/19, staff observed R9 leaving the facility in a taxi around 6:30 p.m. or 6:45 p.m. The note indicated the supervisor was notified and

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| F 689 | Continued From page 8<br>follow-up would occur.<br><br>- 5/30/19, R9 returned to the facility around 12:10 a.m. Staff asked R9 why he had not signed out and R9 had no response. The staff reminded R9 the importance of signing out when he left the facility.<br><br>- 5/30/19, R9 met with the social worker and reminded R9 his guardian preferred he did not leave the facility without a companion. Further, the social worker stated R9 was expected to sign out when leaving the facility whether he was accompanied by a companion or not.<br><br>The progress notes lacked any formal assessment of R9's ability to safely leave the facility on his own. Further, the progress notes lacked documentation of additional times R9 had eloped.<br><br>Review of the report submitted to the State agency (SA) on 5/30/19, at 11:00 p.m. on 5/29/19, revealed R9 was noted by a community member to be in his wheelchair with only socks on, struggling to cross the road. The community member pulled their car over and assisted R9 to safely cross the road across from a gas station. Law enforcement (LE) was notified and the community member waited with R9 until LE arrived. The community member returned to the area 15 minutes later and again found R9 in the middle of the road struggling with mobility of his wheelchair. The community member noted R9 did not appear to be cognitively intact as he stated he would be looking to get a job and the community member recognized R9 would not have been able to work with his current physical condition. The community member assisted R9 | F 689 | | |

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| | 245187 | A. BUILDING _____ B. WING _____ | C 06/05/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **TEXAS TERRACE A VILLA CENTER** | **7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426** |

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| F 689 | Continued From page 9 | F 689 | | |

into her car, loaded the wheelchair, and drove R9 back to the facility after R9 had stated that was where he lived. The community member stated R9's wheelchair was soaked in urine when she loaded it into her car.

On 6/3/19, at 4:30 p.m. community member who brought R9 back to the facility on 5/30/19, stated R9 was pleasantly confused and R9 indicated to her he was looking to obtain a job at the U of M. Further, community member stated R9 struggled maneuvering his wheelchair across the street and R9 had no shoes on. Community member expressed concern for R9's safety being out in the community miles from the facility unsupervised and indicated R9's wheelchair cushion had been noted to be soaked with urine when she folded up the chair and placed it in her car. Additionally, the community member stated they had to wait eight to ten minutes before they were allowed entry into the facility after they arrived. The community member stated she asked the licensed nurse working for a grievance form and was informed he was not sure what they were or where they were located. The community member did contact the facility the next morning and spoke with the administrator to report the event.

On 6/3/19, at 5:11 p.m. R9 was observed seated in a standard wheelchair which had no adaptive safety equipment such as reflective tape, or reflectors. R9 wheeled himself down the hallway towards the dayroom. R9 had a Wanderguard on his right wrist. R9 stated he had the bracelet on his right wrist to prevent him from "escaping." R9 indicated he left the facility on his own one night to go to the library to use the computer. R9 stated he had called the taxi company and they

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arrived at the facility and picked him up. R9 further stated the taxi dropped him off at the bus stop across the street from the gas station. R9 indicated he wheeled himself across the street to the bus stop and took the bus to the library form there. R9 stated staff from the taxi cab and bus assisted with his wheelchair but he had not been sure where his wheelchair had been stored during the trip. R9 indicated he had been gone to the library for about an hour. R9 stated while he had been waiting to take a cab back to the facility, a nice a nice young lady stopped to assist him and brought him back to the facility.

On 6/4/19, at 10:25 a.m. R9 was observed to be coming off the elevator returning to his unit with the Wanderguard alarm sounding. Nurse manager (NM)-A responded and silenced the alarm. R9 stated he had been down on first floor for a while and indicated he could go down to first floor unattended.

On 6/5/19, at 10:00 a.m. R9 was observed wheeling himself off the elevator returning to his unit and the Wanderguard alarm sounded. NM-A responded and silenced the alarm. R9 again stated he had been down on first floor.

On 6/4/19, at 9:12 a.m. nursing assistant (NA)-A stated she was not aware R9 attempted to leave the facility on his own. NA-A indicated R9 had periods of forgetfulness and was not a reliable historian. NA-A indicated R9 had a Wanderguard on his right wrist to prevent R9 from wandering. NA-A further stated if R9 entered the elevator, staff would have to turn the alarm off and R9 could go to the first floor unattended.

On 6/4/19, at 9:34 a.m. NA-B stated R9 was

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independent with transfers and R9 was not able to walk. NA-B stated R9 was not confused and R9 was not allowed to leave the building unattended. NA-B further stated R9 could leave the unit and go to first floor unattended. NA-B expressed she would call the supervisor if R9 was noted to be missing. NA-B stated she was not sure what to do once it had been reported to the supervisor.

On 6/4/19, at 9:45 a.m. licensed practical nurse (LPN)-B stated R9 initially left the building during the first week he had been admitted to the facility. LPN-B stated shortly after R9 had been admitted to the facility, a woman who knew R9 had informed the facility R9 had a history of eloping. LPN-B indicated there was a sign out book located at the nurse's station that would have indicated if a resident left the building. LPN-B stated any resident who was alert and oriented could leave the building unattended as long as they returned by midnight. LPN-B stated staff would have been aware of a resident not being present in the building when a medication or treatment was due as there was no formal rounding protocol utilized by the facility to keep track of all residents. LPN-B also stated she was not aware of any formal community assessment utilized by the facility to assess a resident's ability to leave the facility unattended. LPN-B stated a wandering assessment had been completed on R9, however, confirmed the assessment did not determine R9's ability to safely maneuver in the community unattended. LPN-B indicated there was a "Y code" called last week in the facility and LPN-B stated she was not certain, but thought the code was a way to inform the staff of a missing resident. LPN-B stated she would inform the manager if a resident had been noted to be

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missing and staff would search for the resident. LPN-B indicated she was not sure of the process after searching for the resident and the resident had not been found.

On 6/4/19, at 11:29 a.m. nurse manager (NM)-A indicated the usual facility practice was to complete an elopement assessment on admission and quarterly for residents. NM-A stated if the wander assessment indicated a resident was not an elopement risk he/she could leave the building anytime unattended as long as they were back by midnight. NM-A confirmed R9 should not have been leaving the facility unattended and verified she had been aware R9 left the building unattended. NM-A reviewed the sign out sheet located at the nurse's station and confirmed R9 had left the building unattended on more than one occasion. NM-A stated the Wanderguard bracelet had been placed after R9's elopement which occurred on 5/29/19.

On 6/4/19, at 1:45 p.m. director of rehab (DOR)-E stated R9 had mild cognitive impairments and had difficulties with a visual perception test. DOR-E stated therapy staff had only observed R9 propelling himself in his wheelchair inside the facility. DOR-E confirmed a community safety awareness assessment had not been completed on R9.

On 6/4/19, at 2:22 p.m. the director of social services, (DSS)-A recalled one time R9 had left the building unattended and stated she had not been aware of the multiple times R9 eloped and was aware R9 had a history of eloping prior to admission to the facility. DSS-A indicated R9's guardian had expressed she did not want R9 to leave the facility unattended and stated R9's care

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plan had been updated on 4/10/19, which identified R9 was not to leave the building unattended. The DSS-A stated therapy staff conducted the community assessments for the residents and verified one had not been completed for R9.

On 6/5/19, at 10:05 a.m. director of nursing (DON) stated wandering assessments were expected to be completed upon admission and quarterly. The DON stated it was expected that staff would consider their cognition, mobility status and consider a therapy community assessment as well for those residents who wish to have the ability to leave the building unattended. The DON stated staff had not been aware R9 was not permitted to leave the building unattended. Further, the DON stated if a resident was alert and oriented, he or she had been permitted to leave the facility unattended and if the residents had not returned by midnight, the staff would have to start a search.. The DON confirmed R9 was a safety risk maneuvering unattended in the community and verified staff had not been aware of the actual number of times R9 had left the building unattended. The DON stated she felt the facility had processes to improve on related to resident elopement/assessments as well as a system of keeping track of the residents' whereabouts.

Review of facility policy wandering and elopement guideline revised 3/16/17, indicated upon admission, re-admission, quarterly and with a change of condition, all residents would be evaluated for elopement risk. The policy identified residents who were at risk for eloping would have an elopement risk bracelet applied and resident centered interventions would be

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| F 689 | Continued From page 14<br>placed to prevent elopement. The policy instructed staff to make an attempt to prevent residents from eloping if they were observed leaving the building. Further, the policy instructed staff to inform the charge nurse or DON of the elopement. The policy indicated the charge nurse would update the Administrator, DON and notify police, the attending physician, and resident representative about the missing resident. Additionally, staff were instructed to announce a code white overhead three times followed by the resident room number which would have indicated a resident was missing. | F 689 | | |

Electronically Delivered

June 20, 2019

Administrator
Texas Terrace A Villa Center
7900 West 28th Street
Saint Louis Park, MN 55426

Re: State Nursing Home Licensing Orders - Complaint Number H5187100C, H5187101C, H5187102C, H5187103C, H5187104C, H5187105C, H5187106C, and H5187107C

Dear Administrator:

A complaint investigation was completed on June 5, 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:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

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.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 6/3/19 to 6/5/19, an unannounced abbreviated survey was conducted to determine compliance for state licensure. The following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. | 2 000 | 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. | |

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| 2 000 | Continued From page 1<br><br>The following complaints were not found to be substantiated:<br><br>H5187104C<br>H5187106C<br><br>The following complaints were found to be in compliance at the time of the survey:<br><br>H5187100C<br>H5187101C<br>H5187102C<br>H5187103C<br>H5187105C<br>H5187107C<br><br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | 2 000 | 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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>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 | 2 830 | | 7/12/19 |

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| 2 830 | Continued From page 2<br>written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to comprehensively assess, implement interventions and monitor 1 of 3 residents (R9) at risk for elopement and had actual elopement occurrences in which staff had not been aware of.<br><br>Findings include:<br><br>R9's 14 day Prospective Payment System (PPS) Minimum Data Set (MDS) dated 4/19/19, indicated R9 had diagnoses which included anemia, high blood pressure and depression. R9's MDS further indicated he had moderate impaired cognition and required extensive assistance with bed mobility, transfers, dressing, toileting and personal hygiene. The MDS identified R9 had no behaviors and did not wander.<br><br>R9's admission Care Area Assessments (CAA) dated 4/23/19, indicated R9 had cognitive loss and had rejected care one time during the assessment reference period. The CAA further indicated R9 required extensive assistance with bed mobility, transfers, locomotion, dressing, toileting and personal hygiene. The CAA identified R9 was frequently incontinent of bladder and was at risk for falls. However, the CAA lacked documentation of analysis of wandering or elopement behavior. | 2 830 | 1. Resident #9 has had his elopement assessment updated and reviewed and his care plan interventions reviewed, updated and implemented.<br><br>2. All residents at risk for elopement have had their assessments, care plans and interventions reviewed.<br><br>3. Licensed staff have been re-educated about elopement assessments, care plans and implementation of care plans.<br><br>4. Don/Designees will audit 3 residents per week x2 weeks, then 2 residents per week x2 weeks, then 1 resident per week x2 weeks to ensure elopement assessments, care plans and interventions are appropriately implemented. Audit results will be reviewed by QAPI. | |

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| 2 830 | Continued From page 3<br><br>R9's care plan revised on 5/30/19, indicated R9 had a behavior problem related to alcohol dementia with history of noncompliance with facility policy. R9 had behavior of going out with metro mobility to disapproved places by guardian and would return drunk to previous facility, had current alcohol abuse and was to have no access to alcohol. The care plan indicated R9 was at risk for elopement due to cognitive impairments and identified R9 had a history of calling transportation to leave the facility. The care plan instructed staff to be aware of R9's wander risk as well as distract R9 from wandering by offering pleasant diversions or activities. R9's care plan instructed staff to place a Wanderguard on his wrist and further indicated R9 was not to leave the facility without escort and guardian approval.<br><br>R9's Admission Assessment dated 4/8/19, indicated R9 was not at risk for elopement.<br><br>R9's Wander/Elopement Risk Evaluation dated 5/31/19, indicated R9 was at risk for wandering or elopement. The assessment indicated R9 was cognitively impaired, physically able to leave the building on his own in his wheelchair, and R9 had a history of leaving the unit or the facility. The assessment indicated R9 had exhibited behavior of attempting to exit unit or facility, had a history of calling a cab or metro mobility, and had a guardian who did not want R9 to leave the facility without escort.<br><br>Review of the sign out log stored at the nurse's station revealed R9 left the facility on 4/9/19, 5/14/19, 5/16/19, 5/18/19, and 5/28/19, as verified by his signature each time. The form identified R9 went to Target on two different occasions and to the library on one occasion. The form had one | 2 830 | | |

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| 2 830 | Continued From page 4 | 2 830 | | |

entry which only indicated R9 went out of the facility. The form lacked documentation of an escort assisting R9 to safely go into the community. Further, the form lacked consistent documentation of the dates and times R9 returned to the facility. No further documentation of R9's leaving the facility was noted.

Review of R9's progress notes revealed the following:

- 4/9/19, guardian indicated R9 had a history of elopement and becoming drunk after consuming alcohol. The guardian further indicated R9 had the potential to elope again. The guardian requested a Wanderguard be placed and staff indicated they would discuss with R9 due to resident rights.

- 4/10/19, staff found two bottles of Vodka in R9's room and they were removed. R9 was reminded of the unauthorized substances policy and was informed a Wanderguard would be placed.

- 5/29/19, staff observed R9 leaving the facility in a taxi around 6:30 p.m. or 6:45 p.m. The note indicated the supervisor was notified and follow-up would occur.

- 5/30/19, R9 returned to the facility around 12:10 a.m. Staff asked R9 why he had not signed out and R9 had no response. The staff reminded R9 the importance of signing out when he left the facility.

- 5/30/19, R9 met with the social worker and reminded R9 his guardian preferred he did not leave the facility without a companion. Further, the social worker stated R9 was expected to sign out when leaving the facility whether he was

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| 2 830 | Continued From page 5<br>accompanied by a companion or not.<br><br>The progress notes lacked any formal assessment of R9's ability to safely leave the facility on his own. Further, the progress notes lacked documentation of additional times R9 had eloped.<br><br>Review of the report submitted to the State agency (SA) on 5/30/19, at 11:00 p.m. on 5/29/19, revealed R9 was noted by a community member to be in his wheelchair with only socks on, struggling to cross the road. The community member pulled their car over and assisted R9 to safely cross the road across from a gas station. Law enforcement (LE) was notified and the community member waited with R9 until LE arrived. The community member returned to the area 15 minutes later and again found R9 in the middle of the road struggling with mobility of his wheelchair. The community member noted R9 did not appear to be cognitively intact as he stated he would be looking to get a job and the community member recognized R9 would not have been able to work with his current physical condition. The community member assisted R9 into her car, loaded the wheelchair, and drove R9 back to the facility after R9 had stated that was where he lived. The community member stated R9's wheelchair was soaked in urine when she loaded it into her car.<br><br>On 6/3/19, at 4:30 p.m. community member who brought R9 back to the facility on 5/30/19, stated R9 was pleasantly confused and R9 indicated to her he was looking to obtain a job at the U of M. Further, community member stated R9 struggled maneuvering his wheelchair across the street and R9 had no shoes on. Community member expressed concern for R9's safety being out in | 2 830 | | |

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| 2 830 | Continued From page 6<br>the community miles from the facility unsupervised and indicated R9's wheelchair cushion had been noted to be soaked with urine when she folded up the chair and placed it in her car. Additionally, the community member stated they had to wait eight to ten minutes before they were allowed entry into the facility after they arrived. The community member stated she asked the licensed nurse working for a grievance form and was informed he was not sure what they were or where they were located. The community member did contact the facility the next morning and spoke with the administrator to report the event.<br><br>On 6/3/19, at 5:11 p.m. R9 was observed seated in a standard wheelchair which had no adaptive safety equipment such as reflective tape, or reflectors. R9 wheeled himself down the hallway towards the dayroom. R9 had a Wanderguard on his right wrist. R9 stated he had the bracelet on his right wrist to prevent him from "escaping." R9 indicated he left the facility on his own one night to go to the library to use the computer. R9 stated he had called the taxi company and they arrived at the facility and picked him up. R9 further stated the taxi dropped him off at the bus stop across the street from the gas station. R9 indicated he wheeled himself across the street to the bus stop and took the bus to the library form there. R9 stated staff from the taxi cab and bus assisted with his wheelchair but he had not been sure where his wheelchair had been stored during the trip. R9 indicated he had been gone to the library for about an hour. R9 stated while he had been waiting to take a cab back to the facility, a nice a nice young lady stopped to assist him and brought him back to the facility.<br><br>On 6/4/19, at 10:25 a.m. R9 was observed to be | 2 830 | | |

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| 2 830 | Continued From page 7<br>coming off the elevator returning to his unit with the Wanderguard alarm sounding. Nurse manager (NM)-A responded and silenced the alarm. R9 stated he had been down on first floor for a while and indicated he could go down to first floor unattended.<br><br>On 6/5/19, at 10:00 a.m. R9 was observed wheeling himself off the elevator returning to his unit and the Wanderguard alarm sounded. NM-A responded and silenced the alarm. R9 again stated he had been down on first floor.<br><br>On 6/4/19, at 9:12 a.m. nursing assistant (NA)-A stated she was not aware R9 attempted to leave the facility on his own. NA-A indicated R9 had periods of forgetfulness and was not a reliable historian. NA-A indicated R9 had a Wanderguard on his right wrist to prevent R9 from wandering. NA-A further stated if R9 entered the elevator, staff would have to turn the alarm off and R9 could go to the first floor unattended.<br><br>On 6/4/19, at 9:34 a.m. NA-B stated R9 was independent with transfers and R9 was not able to walk. NA-B stated R9 was not confused and R9 was not allowed to leave the building unattended. NA-B further stated R9 could leave the unit and go to first floor unattended. NA-B expressed she would call the supervisor if R9 was noted to be missing. NA-B stated she was not sure what to do once it had been reported to the supervisor.<br><br>On 6/4/19, at 9:45 a.m. licensed practical nurse (LPN)-B stated R9 initially left the building during the first week he had been admitted to the facility. LPN-B stated shortly after R9 had been admitted to the facility, a woman who knew R9 had informed the facility R9 had a history of eloping. | 2 830 | | |

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| 2 830 | Continued From page 8<br><br>LPN-B indicated there was a sign out book located at the nurse's station that would have indicated if a resident left the building. LPN-B stated any resident who was alert and oriented could leave the building unattended as long as they returned by midnight. LPN-B stated staff would have been aware of a resident not being present in the building when a medication or treatment was due as there was no formal rounding protocol utilized by the facility to keep track of all residents. LPN-B also stated she was not aware of any formal community assessment utilized by the facility to assess a resident's ability to leave the facility unattended. LPN-B stated a wandering assessment had been completed on R9, however, confirmed the assessment did not determine R9's ability to safely maneuver in the community unattended. LPN-B indicated there was a "Y code" called last week in the facility and LPN-B stated she was not certain, but thought the code was a way to inform the staff of a missing resident. LPN-B stated she would inform the manager if a resident had been noted to be missing and staff would search for the resident. LPN-B indicated she was not sure of the process after searching for the resident and the resident had not been found.<br><br>On 6/4/19, at 11:29 a.m. nurse manager (NM)-A indicated the usual facility practice was to complete an elopement assessment on admission and quarterly for residents. NM-A stated if the wander assessment indicated a resident was not an elopement risk he/she could leave the building anytime unattended as long as they were back by midnight. NM-A confirmed R9 should not have been leaving the facility unattended and verified she had been aware R9 left the building unattended. NM-A reviewed the sign out sheet located at the nurse's station and | 2 830 | | |

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| 2 830 | Continued From page 9<br>confirmed R9 had left the building unattended on more than one occasion. NM-A stated the Wanderguard bracelet had been placed after R9's elopement which occurred on 5/29/19.<br><br>On 6/4/19, at 1:45 p.m. director of rehab (DOR)-E stated R9 had mild cognitive impairments and had difficulties with a visual perception test. DOR-E stated therapy staff had only observed R9 propelling himself in his wheelchair inside the facility. DOR-E confirmed a community safety awareness assessment had not been completed on R9.<br><br>On 6/4/19, at 2:22 p.m. the director of social services, (DSS)-A recalled one time R9 had left the building unattended and stated she had not been aware of the multiple times R9 eloped and was aware R9 had a history of eloping prior to admission to the facility. DSS-A indicated R9's guardian had expressed she did not want R9 to leave the facility unattended and stated R9's care plan had been updated on 4/10/19, which identified R9 was not to leave the building unattended. The DSS-A stated therapy staff conducted the community assessments for the residents and verified one had not been completed for R9.<br><br>On 6/5/19, at 10:05 a.m. director of nursing (DON) stated wandering assessments were expected to be completed upon admission and quarterly. The DON stated it was expected that staff would consider their cognition, mobility status and consider a therapy community assessment as well for those residents who wish to have the ability to leave the building unattended. The DON stated staff had not been aware R9 was not permitted to leave the building unattended. Further, the DON stated if a resident | 2 830 | | |

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| 2 830 | Continued From page 10<br>was alert and oriented, he or she had been permitted to leave the facility unattended and if the residents had not returned by midnight, the staff would have to start a search.. The DON confirmed R9 was a safety risk maneuvering unattended in the community and verified staff had not been aware of the actual number of times R9 had left the building unattended. The DON stated she felt the facility had processes to improve on related to resident elopement/assessments as well as a system of keeping track of the residents' whereabouts.<br><br>Review of facility policy wandering and elopement guideline revised 3/16/17, indicated upon admission, re-admission, quarterly and with a change of condition, all residents would be evaluated for elopement risk. The policy identified residents who were at risk for eloping would have an elopement risk bracelet applied and resident centered interventions would be placed to prevent elopement. The policy instructed staff to make an attempt to prevent residents from eloping if they were observed leaving the building. Further, the policy instructed staff to inform the charge nurse or DON of the elopement. The policy indicated the charge nurse would update the Administrator, DON and notify police, the attending physician, and resident representative about the missing resident. Additionally, staff were instructed to announce a code white overhead three times followed by the resident room number which would have indicated a resident was missing.<br><br>SUGGESTED METHOD OF CORRECTION:<br>The director of nursing (DON) or designee could develop, review and/or revise policies and procedures related to the identification of | 2 830 | | |

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| 2 830 | Continued From page 11<br>residents at risk for elopement, assessment and care plan interventions to address elopements. The DON or designee could educate all appropriate staff on the policies and procedures and develop a monitoring system to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) Days | 2 830 | | |
| 2 920 | MN Rule 4658.0525 Subp. 6 B Rehab - ADLs<br><br>Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that:<br>B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide timely assistance with incontinence cares for 1 of 1 resident (R5) who was dependent on facility staff for incontinence cares.<br><br>Findings Include:<br><br>Review of R5's annual Minimum Data Set (MDS) dated 5/3/19, identified R5 had diagnoses which included dementia, diabetes and schizophrenia. The MDS identified R5 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, toileting and | 2 920 | 1. Resident #5 has had a new bladder assessment with toileting plan and care plan updated. Toileting is being provided per his care plan.<br><br>2. All residents requiring assistance with toileting are being toileted per plan of care.<br><br>3. Staff have been re-educated regarding toileting per plan of care.<br><br>4. DON/Designee will audit 5 residents per week x 2 weeks, then 3 residents per week x 2 weeks, then 2 residents per week x1 week to ensure toileting plans are | 7/12/19 |

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| 2 920 | Continued From page 12<br>personal hygiene. The MDS identified R5 was always incontinent of urine and was not on a toileting program.<br><br>Review of R5's ADL Care Area Assessment (CAA) dated 5/3/19, identified R5 had both short and long term memory loss. The CAA identified R5 had moderate difficulty understanding others and had difficulty making himself understood. The CAA identified R5 was incontinent of urine, required extensive assistance with toileting and personal hygiene and would be checked and changed every two hours for incontinence.<br><br>R5's current bladder assessment dated 4/30/19, identified R5 was always incontinent of urine, wore a disposable incontinent brief. The bladder assessment identified R5 was dependent on nursing staff for incontinence cares and was on a routine check and change program.<br><br>Review of R5's current care plan revised, 5/20/19, revealed R5 was always incontinent of urine, wore an incontinence brief and required extensive assistance of two with checking and changing every two hours.<br><br>On 6/3/19, at 3:08 p.m. R5 was observed seated in a wheelchair in the common area, by the nurse's station. R5 wore gray sweatpants, tennis shoes and a t-shirt. R5's sweatpants had no visible wetness.<br><br>-at 4:35 p.m. R5 remained seated in a wheelchair in the common area with several other residents while an activity aid read to the group. R5's sweatpants had no visible wetness.<br><br>-at 5:11 p.m. R5 remained seated in a wheelchair in the common area, with several other residents. | 2 920 | implemented. Results of audits will be reviewed in QAPI. | |

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| 2 920 | Continued From page 13<br><br>At that time, the activity aid stopped reading. R5 picked up a magazine and began to page through it. R5's sweatpants had a large wet spot over his groin.<br><br>-at 5:28 p.m. R5 wheeled himself towards his room, stopped and spoke with NA-A to ask what was for dinner. NA-A answered R5, looked down to his groin and stated R5 needed to be changed. NA-A proceeded to wheel R5 to his room. At that time, NA-A stated R5 had been incontinent of urine, which had soaked through his clothing. R5 wheeled himself in front of the television set, took hold of the remote control and turned on the television.<br><br>-at 5:30 p.m. registered nurse manager (NM)-A entered R5's room, wheeled R5 to the end of his bed, removed his footrests and R5 proceeded to reach out and hold the end of the bed and stood up. At that time, NM-A confirmed R5 had been incontinent of a large amount of urine, which had soaked through his incontinent brief, sweatpants and onto the towel covered seat of the wheelchair. NA-A assisted R5 to remove the urine saturated incontinent brief, cleanse, donne a clean incontinent brief, and put on a pair of shorts. NM-A removed the wet white towel from R5's wheelchair seat and applied a pressure relieving cushion. NM-A was not observed to cleanse the seat of R5's wheelchair. R5 was assisted to sit on the cushioned seat of the wheelchair, wheeled himself in front of the television and turned up the volume.<br><br>On 6/3/19, at 5:38 p.m. NM-A stated R5 was always incontinent of urine and would frequently have episodes of large amount of urine incontinence which would end up saturating the incontinent brief and saturate his clothing with | 2 920 | | |

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| 2 920 | Continued From page 14<br>urine. NM-A confirmed R5 was on a routine every two hour check and change program.<br><br>On 6/3/19, at 5:42 p.m. NA-A stated she had last checked and changed R5 at 2:30 that afternoon, and had thought another NA had assisted R5 to change his incontinent brief between 2:30 p.m. and 5:30 p.m. NA-A stated R5 was always incontinent of urine and wore an incontinent brief daily. NA-A stated R5 required extensive assistance with all of his ADL's and was checked and changed every two hours for incontinence. Further, NA-A indicated R5 would frequently soak through his incontinent brief and his clothing when he was incontinent of urine.<br><br>On 6/4/19, at 11:50 a.m. licensed practical nurse (LPN)-B stated R5 was totally dependent on staff for checking and changing every two hours. LPN-B stated at times R5 would refuse checking and changing and indicated R5 frequently would soil through his brief and onto his clothing.<br><br>On 6/4/19, at 11:54 a.m. during a follow up interview, NM-A stated R5 required "cares in pairs," due to combativeness with cares and a history of R5 reporting staff had hit him. NM-A stated R5 required assistance with checking and changing his incontinent brief every two hours. She stated R5 drank large amounts of fluids during the day and felt R5 soiled through his brief and clothing as a result of large fluid intake. NM-A confirmed R5's excessive fluid intake had not been identified as a factor of his incontinence. NM-A confirmed R5 routinely soaked through his disposable incontinent brief and had R5 had not been re-assessed for another type of incontinent product or changes in his toileting schedule.<br><br>On 6/5/19, at 9:37 a.m. the director of nursing | 2 920 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 00144 | A. BUILDING: _____ B. WING _____ | C 06/05/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TEXAS TERRACE A VILLA CENTER | 7900 WEST 28TH STREET SAINT LOUIS PARK, MN 55426 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 920 | Continued From page 15<br>(DON) stated she would expect R5's care plan to be followed and staff to offer checking and changing every two hours. The DON stated she would have expected R5's urinary incontinence to be re-assessed to ensure the incontinent product and frequency of checking and changing were appropriate for R5.<br><br>Review of a facility policy titled, Bowel and Bladder management dated 11/28/17, identified it was the facility's policy to ensure all residents were accurately and comprehensively assessed for urinary incontinence upon admission, quarterly and as needed. The policy revealed residents who had been assessed as having urinary incontinence would then be placed on a toileting program which included routine checking and changing.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could re-educate all staff related to implementing individualized care plans in regards to toileting care needs. The DON could develop a system to audit and monitor for compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 920 | | |