DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 1, 2019

Administrator
Centennial Gardens For Nursing & Rehabilitation
3245 Vera Cruz Avenue North
Crystal, MN 55422

RE: Project Number H5289087C

Dear Administrator:

On August 1, 2019, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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.

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

Electronically delivered
July 17, 2019

Administrator
Centennial Gardens For Nursing & Rehabilitation
3245 Vera Cruz Avenue North
Crystal, MN 55422

RE: Project Number H5289087C

Dear Administrator:

On July 2, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is August 11, 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), i.e., the plan of correction should be directed to:

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

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 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 October 2, 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 January 2, 2020 (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

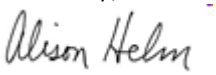
You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_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,



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
	245289	A. BUILDING _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL GARDENS FOR NURSING & REHABILITATION	**3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422**

(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 7/1/19 and 7/2/19, an unannounced abbreviated survey was completed at your facility to conduct a complaint investigation. Centennial Gardens was not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was substantiated: H5289087C and citations were issued at F558 and F686. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to have a call light within reach for 1 of 1 clients (R1) that was dependent	F 558	1. Resident R1 call bell clip has been replaced and secured to a location that can be accessed by the resident.	7/26/19

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

Electronically Signed | 07/23/2019

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 558	Continued From page 1 and needed staff assistance for daily needs. Findings include: R1 face sheet dated 7/2/19 indicated diagnoses including quadriplegia and adjustment disorder. The admission multiple data set (MDS) assessment dated 2/13/19 indicated R1 was cognitively intact with a brief inventory of mental status (BIMS) score of 15. The care area assessment indicated R1 had impaired range of motion to both upper extremities, was a total assist for bed mobility, grooming, dressing, hygiene eating and toileting. The current care plan dated 7/2/19 indicated that R1 was totally dependent on staff for cares, the current physicians orders indicated R1 was on strict bedrest. During an observation of R1 on 7/1/19 at 1:30 p.m., he was in bed, there was a grey round soft touch call light with the cord wound in the side rail and hanging below the edge of the bed. At 3:30 p.m. on 7/1/19 R1 was heard yelling out for staff to help, this was loud and heard from the hallway 4 rooms away, staff went into the room and closed the door. On 7/2/19 at 8;30 a.m., R1 was in bed, the call light was again located draped off the side of the bed out of reach,there was no clip on the cord to attach to resident's gown or sheet. At 12:00 p.m., on 7/2/19 R1 was interviewed and verified that he was able to use the call light provided, it was often left out of reach, and had never had a clip to keep it secured. R1 stated that he had many issues with the staff responding to the call lights timely and providing cares, said he just screams when he needs cares but even then often does not get help.. During the interview R1	F 558	2. 2. The Director of Maintenance has inspected all resident call bells to insure all have the required clip attach ed to the call bell cord. Any that were identified as missing were replaced immediately. 3. Nursing Assistants will be re-educated on placing call bells within reach of the resident 4. Unit managers, unit nurse, or designee are required to include call bell placement during their scheduled rounds to assure resident access to their call Bells and able to be safely secured with a call bell clip 5. The Administrator along with the Director of Nursing have developed an audit tool to monitor compliance for call bells being securely placed and accessible to residents The Director of Nursing/designee will complete audits weekly X 4 Weeks MonthlytX3 months and then quarterly on an ongoing schedule. All finding will be reported to the QAPI Committee for follow up recommendations. All negative findings at the time of the audit will be reported to the Administrator immediately for follow up	

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F 558	Continued From page 2	F 558		

used a cell phone touchscreen to access several items.

During an observation with LPN-A at 1:30 p.m. the call light was on the side of bed dangling and out of reach. LPN-A verified there was no clip to keep within reach- she said she was new and also wondered about this.

During an interview with a resident in the room next to R1 on 7/2/19 at 8:45 a.m., stated that he has to go get staff for R1 when he is yelling for staff, He stated sometimes the call light was on and sometimes it was out of reach, " if (R1) can reach it will put on call light and it can be on for long periods of time. He stated at least twice a day goes to get nurses, and night shift was the worst.

Review of the call light logs from 6/1/19 to 6/30/19 for R1 revealed the light was on for 62 minutes on 6/1/19 at 3:37 a.m., for 64 minutes on 6/4/19 at 10:34 p.m., 48 minutes on 6/4/19 at 1:07 p.m., 65 minutes on 6/7/19 at 12:00 p. m., 78 minutes on 6/9/19 at 8:30 a.m., 50 minutes on 6/9/19 at 7:07 p.m., 66 minutes on 6/12/19, 53 minutes on 6/19/19 at 4:00 a.m., and there were 7 other times from 6/25/19 to 6/30/19 that the call light was on for over 60 minutes.

The unit social service assistant was interviewed on 7/2/19 at 2:15 p.m., and stated R1 had talked with her about call lights and said he felt the aides were ignoring him, but there were no concerns lately. She felt a reasonable amount of time to wait would be 10 minutes.

The director of nursing was interviewed on 7/2/19 at 4:00 p.m., 7/2/19 4:00 p.m., she verified that

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F 558	Continued From page 3 the call light time response times can be reviewed on their system but they would only do it if a complaint was made. She verified that R1 should have a call light in reach at all times and staff should respond timely. The DON stated that special call lights like the soft touch should be clipped to be in reach for the resident, she was not aware the R1 did not have a clip on the cord of the call light.	F 558		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to assess and provide necessary services for 2 of 3 residents (R1 , R3) reviewed for pressure ulcers. Findings include: R1 R1 face sheet dated 7/2/19 indicated diagnoses	F 686	1. R1 Wounds were assessed on July 3rd by the unit manager. Assessment included but not limited to size and stage of wounds. Physician was notified of wound on July 3rd. R3□s heal wound was assessed on July 2nd. Assessment included but not limited to size and stage of wounds. Physician was notified of wound on July 2nd. 2. Residents with pressure injuries were	7/26/19

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F 686	Continued From page 4 including quadriplegia and pressure ulcer stage 3 on left buttock. The admission multiple data set (MDS) assessment dated 2/13/19 indicated R1 was cognitively intact with a brief inventory of mental status (BIMS) score of 15. The skin assessment indicated R1 was admitted with 1 stage 3 pressure ulcer., and was totally dependent for bed mobility and transfers. The care area assessment (CAA) indicated R1 had risk factors including impaired mobility, impaired sensation, current pressure ulcer, and inability to off load pressure. The CAA noted that R1 was receiving intravenous antibiotics, needed turning , a special mattress, and extra protein in diet. The current care plan dated 7/2/19 indicated that R1 was totally dependent on staff for cares, and required turning every 2 hours to prevent further skin breakdown. The care plan for pressure ulcer care dated 2/8/19 indicated "Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate (drainiage). The treatment record indicated that during May 2019 until surgery on 6/20/19, R1 received daily wound care to cleanse, pack with gauze soaked in Vashe solution, cover with ointment and dressing, and to have wound vac in place. The medical record indicated that R1 had been hospitalized and had a surgical flap repair to the pressure wound on 6/20/19. Review of the records from visits to the wound clinic for March, April , and May 2019 did not include measurement or description of the condition of the wound. The facility had assessments of the pressure wound was documented weekly during March,	F 686	assessed by the unit managers and documented on Weekly wound documentation flow sheets. At the time of the assessment, residents were assessed for need of pressure relieving cushions/positioning devices. 3. ADON will include weekly wound rounds as part of her risk management responsibilities. Nurses were in-serviced on facility wound policy/ Resident positioning/pressure relieving devices will be included and documented on facility Point of Care Program. CNA will receive education related to this as well as use and importance of said devices. The facility has added weekly wound/risk meeting to review all wounds and progress toward healing 4. The Administrator and DON have developed audit to monitor compliance with weekly wound documentation/tracking as well as any pressure relieving/positioning devices for supportive wound healing. These audits will be complete by DON/designee monthly on an ongoing basis as part of the facilities risk managements program. All result will be reported to the QAPI Committee as scheduled for follow up recommendation Negative finding will be reported to the Administrator immediately.	

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F 686	Continued From page 5	F 686		

then on 4/1/19 and 5/6/19. There were no weekly assessments of the wound since 5/6/19 in the medical record.

The nurse manager was interviewed on 7/2/19 at 1:30 p.m. and stated she was not able to locate any additional assessments of the wound for R1 other than 4/1/19 and 5/6/19, she stated that they were usually done weekly on wound rounds with a consulting wound physician, but R1 was not on their service and went out to a wound clinic. She verfied that weekly assessment of the wound should take place. She verified that there was no assessment of the surgical wound since readmitted from the hospital last week.

The director of nursing (DON) was interviewed on 7/2/19 4:00 p.m., and verified that wounds should be assessed weekly by nursing with measurements and the condition of the wound. She stated there had been a gap of time between nurse managers and it was the responsibility of all nurses to assure wound rounds to be done for residents with pressure ulcers.

The facility policy (undated) titled 'Pressure Ulcer Risk Assessment' indicated skin would be assessed on a weekly basis or more frequently if indicated, and documentation should include the condition of the skin including any area of concern from pressure.

R3

R3 face sheet dated 7/2/19 indicated a diagnoses of open wounds to the right and left thigh, on 5/13/19 a stage 1 pressure ulcer to the right heel and unstageable to the left heel. The admission MDS dated 5/17/19 indicated 4 stage 1 pressure

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F 686	Continued From page 6 ulcers, 1 stage 2, 1 unstageable, and 2 unstageable deep tissue injury. The CAA dated 5/17/19 indicated R3 was at risk of pressure ulcer development due to immobility and decreased sensation. R3 was hospitalized on 6/8/19 a discharge MDS was completed, and on 6/22/19 a reentry MDS was done. The admission nursing assessment on 6/22/19 indicated R3 had two pressure wounds on the back of each thigh. The feet were assessed to have edema but not skin alterations. The note dated 7/1/19 by the consulting wound care physician indicated the feet were to be on a pillow, and described 2 pressure ulcers on the back of each thigh, no other skin alterations were noted. During observations of R3 on 7/1/19 2:30 p.m., was observed in a bariatric bed with HOB elevated to 30 degrees, there were pillow foot boots (2 pair on window sill), and feet were covered by blankets. 7/2/19 9:30 am during observations of wound care to open areas of the thighs, noted no pillow boots on feet bare with the left foot having a darkened area appearing as a purple bruise approximately 4 cm by 3 cm. R3 had 2 sets of pillow boots in the room and when asked why he didn't wear them R3 stated they hurt when on. RN- A stated he should have them on but refused. The bed had an air mattress with a bolster at the end to hold the mattress, R3's feet were resting in direct contact with the foot board of the bed when he was positioned on his back. RN-A stated the bolster should be up to protect the feet but it does not stay in place. Review of the record did not contain education on the risks and benefits of the pillow boots, or the	F 686		

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F 686	Continued From page 7 residnet's refusal of the use of the boots. During an interview with the nurse manager RN-A on 7/2/19 at 2:00 p.m., she stated she had been informed of the new area on the left foot last night, thought it might be a blister but had not assessed yet. She stated she had talked to therapy about ideas to protect feet from pressure, she had not implemented floating heel on a pillow since refusal of the boots. She stated she had not notified the physician because she was on vacation. The DON was interviewed 7/2/19 at 4:00 p.m. and stated all new areas of skin alteration should be assessed, new interventions implemented, and reported to a physician. She verified that refusals of interventions should be documented and risks and benefits presented to the resident. The facility policy "pressure ulcer risk assessment" (undated) indicated if a new pressure are was identified the family, and physican were to be notified. The policy directed that if a resident refused treatment the reason of refusals and resident's response to explaining the risks and benefits of refusing were to be documented,	F 686		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 17, 2019

Administrator
Centennial Gardens For Nursing & Rehabilitation
3245 Vera Cruz Avenue North
Crystal, MN 55422

Re: State Nursing Home Licensing Orders - Complaint Number H5289087C

Dear Administrator:

A complaint investigation was completed on July 2, 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:

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00255	A. BUILDING: _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL GARDENS FOR NURSING & REH	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

(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
2 000	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 7/1/19 and 7/2/19 surveyors of this Department's staff visited the above provider for a complaint investigation to investigate complaint H5289087C. Correction orders were issued The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is	2 000		

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2 000	Continued From page 1 not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to assess and provide necessary services for 2 of 3 residents (R1 , R3) reviewed for pressure ulcers. Findings include: R1 R1 face sheet dated 7/2/19 indicated diagnoses including quadriplegia and pressure ulcer stage 3	2 900	Corrected	7/26/19

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2 900	Continued From page 2 on left buttock. The admission multiple data set (MDS) assessment dated 2/13/19 indicated R1 was cognitively intact with a brief inventory of mental status (BIMS) score of 15. The skin assessment indicated R1 was admitted with 1 stage 3 pressure ulcer., and was totally dependent for bed mobility and transfers. The care area assessment (CAA) indicated R1 had risk factors including impaired mobility, impaired sensation, current pressure ulcer, and inability to off load pressure. The CAA noted that R1 was receiving intravenous antibiotics, needed turning , a special mattress, and extra protein in diet. The current care plan dated 7/2/19 indicated that R1 was totally dependent on staff for cares, and required turning every 2 hours to prevent further skin breakdown. The care plan for pressure ulcer care dated 2/8/19 indicated "Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate (drainiage). The treatment record indicated that during May 2019 until surgery on 6/20/19, R1 received daily wound care to cleanse, pack with gauze soaked in Vashe solution, cover with ointment and dressing, and to have wound vac in place. The medical record indicated that R1 had been hospitalized and had a surgical flap repair to the pressure wound on 6/20/19. Review of the records from visits to the wound clinic for March, April , and May 2019 did not include measurement or description of the condition of the wound. The facility had assessments of the pressure wound was documented weekly during March, then on 4/1/19 and 5/6/19. There were no weekly assessments of the wound since 5/6/19 in the	2 900		

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2 900	Continued From page 3 medical record. The nurse manager was interviewed on 7/2/19 at 1:30 p.m. and stated she was not able to locate any additional assessments of the wound for R1 other than 4/1/19 and 5/6/19, she stated that they were usually done weekly on wound rounds with a consulting wound physician, but R1 was not on their service and went out to a wound clinic. She verfied that weekly assessment of the wound should take place. She verified that there was no assessment of the surgical wound since readmitted from the hospital last week. The director of nursing (DON) was interviewed on 7/2/19 4:00 p.m., and verified that wounds should be assessed weekly by nursing with measurements and the condition of the wound. She stated there had been a gap of time between nurse managers and it was the responsibility of all nurses to assure wound rounds to be done for residents with pressure ulcers. The facility policy (undated) titled 'Pressure Ulcer Risk Assessment' indicated skin would be assessed on a weekly basis or more frequently if indicated, and documentation should include the condition of the skin including any area of concern from pressure. R3 R3 face sheet dated 7/2/19 indicated a diagnoses of open wounds to the right and left thigh, on 5/13/19 a stage 1 pressure ulcer to the right heel and unstageable to the left heel. The admission MDS dated 5/17/19 indicated 4 stage 1 pressure ulcers, 1 stage 2, 1 unstageable, and 2 unstageable deep tissue injury. The CAA dated 5/17/19 indicated R3 was at risk of pressure ulcer	2 900		

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2 900	Continued From page 4 development due to immobility and decreased sensation. R3 was hospitalized on 6/8/19 a discharge MDS was completed, and on 6/22/19 a reentry MDS was done. The admission nursing assessment on 6/22/19 indicated R3 had two pressure wounds on the back of each thigh. The feet were assessed to have edema but not skin alterations. The note dated 7/1/19 by the consulting wound care physician indicated the feet were to be on a pillow, and described 2 pressure ulcers on the back of each thigh, no other skin alterations were noted. During observations of R3 on 7/1/19 2:30 p.m., was observed in a bariatric bed with HOB elevated to 30 degrees, there were pillow foot boots (2 pair on window sill), and feet were covered by blankets. 7/2/19 9:30 am during observations of wound care to open areas of the thighs, noted no pillow boots on feet bare with the left foot having a darkened area appearing as a purple bruise approximately 4 cm by 3 cm. R3 had 2 sets of pillow boots in the room and when asked why he didn't wear them R3 stated they hurt when on. RN- A stated he should have them on but refused. The bed had an air mattress with a bolster at the end to hold the mattress, R3's feet were resting in direct contact with the foot board of the bed when he was positioned on his back. RN-A stated the bolster should be up to protect the feet but it does not stay in place. Review of the record did not contain education on the risks and benefits of the pillow boots, or the residnet's refusal of the use of the boots. During an interview with the nurse manager RN-A on 7/2/19 at 2:00 p.m., she stated she had been	2 900		

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2 900	Continued From page 5 informed of the new area on the left foot last night, thought it might be a blister but had not assessed yet. She stated she had talked to therapy about ideas to protect feet from pressure, she had not implemented floating heel on a pillow since refusal of the boots. She stated she had not notified the physician because she was on vacation. The DON was interviewed 7/2/19 at 4:00 p.m. and stated all new areas of skin alteration should be assessed, new interventions implemented, and reported to a physician. She verified that refusals of interventions should be documented and risks and benefits presented to the resident. The facility policy "pressure ulcer risk assessment" (undated) indicated if a new pressure are was identified the family, and physican were to be notified. The policy directed that if a resident refused treatment the reason of refusals and resident's response to explaining the risks and benefits of refusing were to be documented, SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		

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21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to have a call light within reach for 1 of 1 clients (R1) that was dependent and needed staff assistance for daily needs. Findings include: R1 face sheet dated 7/2/19 indicated diagnoses including quadriplegia and adjustment disorder. The admission multiple data set (MDS) assessment dated 2/13/19 indicated R1 was cognitively intact with a brief inventory of mental status (BIMS) score of 15. The care area assessment indicated R1 had impaired range of motion to both upper extremities, was a total assist for bed mobility, grooming, dressing, hygiene eating and toileting. The current care plan dated 7/2/19 indicated that R1 was totally dependent on staff for cares, the current physicians orders indicated R1 was on strict bedrest. During an observation of R1 on 7/1/19 at 1:30 p.m., he was in bed, there was a grey round soft	21810	Corrected	7/26/19

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21810	Continued From page 7	21810		

touch call light with the cord wound in the side rail and hanging below the edge of the bed.
At 3:30 p.m. on 7/1/19 R1 was heard yelling out for staff to help, this was loud and heard from the hallway 4 rooms away, staff went into the room and closed the door.
On 7/2/19 at 8;30 a.m., R1 was in bed, the call light was again located draped off the side of the bed out of reach,there was no clip on the cord to attach to resident's gown or sheet.
At 12:00 p.m., on 7/2/19 R1 was interviewed and verified that he was able to use the call light provided, it was often left out of reach, and had never had a clip to keep it secured. R1 stated that he had many issues with the staff responding to the call lights timely and providing cares, said he just screams when he needs cares but even then often does not get help.. During the interview R1 used a cell phone touchscreen to access several items.

During an observation with LPN-A at 1:30 p.m. the call light was on the side of bed dangling and out of reach. LPN-A verified there was no clip to keep within reach- she said she was new and also wondered about this.

During an interview with a resident in the room next to R1 on 7/2/19 at 8:45 a.m., stated that he has to go get staff for R1 when he is yelling for staff, He stated sometimes the call light was on and sometimes it was out of reach, " if (R1) can reach it will put on call light and it can be on for long periods of time. He stated at least twice a day goes to get nurses, and night shift was the worst.

Review of the call light logs from 6/1/19 to 6/30/19 for R1 revealed the light was on for 62 minutes on 6/1/19 at 3:37 a.m., for 64 minutes on

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21810	Continued From page 8 6/4/19 at 10:34 p.m., 48 minutes on 6/4/19 at 1:07 p.m., 65 minutes on 6/7/19 at 12:00 p. m., 78 minutes on 6/9/19 at 8:30 a.m., 50 minutes on 6/9/19 at 7:07 p.m., 66 minutes on 6/12/19, 53 minutes on 6/19/19 at 4:00 a.m., and there were 7 other times from 6/25/19 to 6/30/19 that the call light was on for over 60 minutes. The unit social service assistant was interviewed on 7/2/19 at 2:15 p.m., and stated R1 had talked with her about call lights and said he felt the aides were ignoring him, but there were no concerns lately. She felt a reasonable amount of time to wait would be 10 minutes. The director of nursing was interviewed on 7/2/19 at 4:00 p.m., 7/2/19 4:00 p.m., she verified that the call light time response times can be reviewed on their system but they would only do it if a complaint was made. She verified that R1 should have a call light in reach at all times and staff should respond timely. The DON stated that special call lights like the soft touch should be clipped to be in reach for the resident, she was not aware the R1 did not have a clip on the cord of the call light. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all residents have a call ligth within reach and educate staff to respond timely.The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		

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