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

Electronically delivered

July 10, 2020

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

RE: CCN: 245289
Survey Start Date: March 17, 2020

Dear Administrator:

On July 10, 2020 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 3, 2020. Per the CMS Memo QSO-20-20-All, enforcement remedies were suspended from March 23, 2020 to May 31, 2020 and will be evaluated at a later date.

The CMS Region V Office may notify you of their determination regarding any remedies.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
May 15, 2020

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

SUBJECT: SURVEY RESULTS
CCN: 245289
Cycle Start Date: March 17, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES
The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS
On May 7, 2020, the Minnesota Department of Health completed a complaint investigation at Centennial Gardens For Nursing & Rehabilitation to determine if your facility was in compliance with Federal requirements related to the complaint. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION
You must submit an acceptable electronic plan of correction (ePOC) for the enclosed deficiencies that were cited during the May 7, 2020 survey. Centennial Gardens For Nursing & Rehabilitation may choose to delay submission of an ePOC until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit an ePOC. 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. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation.

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; and
- The date that each deficiency will be corrected.

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

Susanne Reuss, Unit Supervisor
Fax: (651) 215-9697
Email: susanne.reuss@state.mn.us

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the May 7, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Susanne Reuss, Unit Supervisor
Fax: (651) 215-9697
Email: susanne.reuss@state.mn.us

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the

Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Centennial Gardens For Nursing & Rehabilitation may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES
The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@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 05/07/2020

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 5/2/2020, to 5/7/2020, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5289106C, H5289107C. Deficiency issued at F610. as a result of the investigation an additional deficiency was identified at F689. 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 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the	F 610		7/3/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 07/01/2020

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 610	Continued From page 1 investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to thoroughly investigate allegations of abuse for 1 of 3 residents (R8) reviewed for abuse. Findings include: R8's quarterly Minimum Data Set dated 3/9/20, indicated she was moderately cognitively impaired and required assistance for bed mobility, transfers and toileting. The MDS indicated R8 did not ambulate. R8's care plan dated 3/3/20, identified R8 as vulnerable and at risk for abuse related to anxiety, cognitive impairment and dementia. The care plan indicated R8 would be kept safe and free from abuse. The care plan directed staff to remove R8 from potentially dangerous situations and indicated she preferred female staff only to provide personal cares. A report dated 4/20/2020, indicated R8's FM left a voice message to the social worker (SW)-A indicating a nursing assistant (NA) had called his wife a "white b****." R8's FM further reported the NA had "violently pushed R8's chair and she almost fell off of the chair. FM requested immediate discharge orders for R8.	F 610	R 8 is no longer a resident at the facility. A risk management incident was created to record this incident and all elements will be inserted. Resident abuse allegations from survey exit until current were reviewed for thorough completion. Any missing items will be noted. All future allegations of abuse will be reviewed by the corporate team prior to submission to the state agency. The IDT team was in-serviced on the Abuse policy on 6/17/2020. Audits on thorough completion of abuse reports will begin 2x week x 2 weeks, then monthly to ensure compliance. Social Service Director or designee is responsible for compliance. Audits will be reviewed by the administrator and taken to QAPI for review and recommendation. Compliance: 7/3/2020	

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F 610	Continued From page 2	F 610		

A facility initiated investigation dated 4/27/20, indicated R8's FM was upset when he was not allowed to come into the building and could no longer take R8 home on a leave of absence. The report indicated the administrator interviewed the accused NA who denied making the statement and denied pushing R8's chair.

A copy of the investigation was requested. An e-mail was sent by the vice president of operation indicating the following investigation:

4/20/20, untitled, indicated "around 4:30 this afternoon this writer [unidentified] received information from nursing staff that it was reported to them that resident would not be returning after dialysis." The writer had spoken to the nurse practitioner (NP) who stated R8's FM left a message with Twin City Physican's(TCP) that he was not wanting to bring resident back to facility. This writer called the FM to discuss matter with him and a voice mail was left. FM left a second voice mail with TCP stating he does not want resident to return to facility. TCP NP and this writer spoke for a second time and NP stated that she would be talking to the FM to state she was fine with R8 discharging to home with nursing staff connecting with pharmacy for seven day supply of medication and for resident to follow up with physician within seven days.

Additionally this writer talked to NA who stated on 4/20/2020 that he was just calmly trying to help resident with her cares and needs and she started yelling, screaming and swearing at him. A nurse was also asked about resident's care on 4/20/2020, she too verified that she and the NA were in the room trying to help resident and talk

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F 610	Continued From page 3	F 610		

to her about how the both of them were going to help her from the bed to wheelchair and she continued to yell, scream and swear until other staff arrived to help transfer resident in wheelchair so that she could go to her appointment.

The medical record lacked evidence of any further investigation related to the allegation of verbal and physical abuse.

During interview on 5/7/20, at 2:16 p.m. the director of nursing stated she was not in the facility when the allegation was made and stated she thought SW-A had done the investigation. The interim administrator stated he would expect follow up with staff and would have the accused NA put on suspension while under investigation. The interim administrator further stated he would expect interviews with other residents on the unit. The vice president of operations stated she would have expected education be completed with all of the staff in the facility.

A facility policy titled Abuse Investigations, dated 12/20/19, and reviewed 4/24/20, indicated: should an incident or suspected incident of resident abuse, mistreatment, neglect, exploitation or mistreatment, including injuries of unknown source be reported, the administrator, or his/her designee, will initiate a state agency (SA) report immediately but no later than 2 hours after the allegation was made if the events that cause the allegation involve abuse or result in serious bodily injury. These situations should be fully investigated and documented until findings are communicated. The policy indicated the individual conducting the investigation will, as a minimum:

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F 610	Continued From page 4 a. Review the completed documentation forms; b. Review the resident's medical record to determine events leading up to the incident; c. Interview the person(s) reporting the incident; d. Interview any witnesses to the incident; e. Interview the resident (as medically appropriate); f. Interview the resident's attending physician as needed to determine the resident's current level of cognitive function and medical condition; g. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; h. Interview the resident's roommate, family members, and visitors; i. Interview other residents to whom the accused employee provides care or services; and j. Review all events leading up to the alleged incident.	F 610		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide therapeutic diets as ordered by the physician for 7 of 24 residents (R1, R2, R3, R4, R5, R6, R7) reviewed for dining.	F 689	R 1, 3, 4 have since passed away. R 6 and R 8 discharged from the facility. R2, 5 and R7 remain in the facility. During survey, meal tickets were printed immediately and distributed to the dietary department for use. Therapeutic diets	7/3/20

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F 689	Continued From page 5 Findings include: R1's quarterly Minimum Data Set (MDS) dated 2/25/20, indicated he was severely cognitively impaired and required extensive assitance from one staff to eat. R1's Clinical Physicians Order dated 1/20/20, identified a regular pureed texture diet with honey consistency liquids. R2's quarterly MDS dated 4/9/20, indicated he was moderately cognitively impaired and required supervision while eating. R2's Clinical Physican's Order dated 11/19/19, identified a mechanical chopped texture diet with thin liquids. R3's quarterly MDS dated 2/14/20, indicated he was severely cognitively impaired and required total assistance from staff to eat. R3's Clinical Physican's Order dated 3/13/19, identified a mechanical ground texture diet with thin liquids. R4's quarterly MDS dated 3/23/20, indicated she was severely cognitively impaired and ate independently after set up. R4's Clinical Physican's Order dated 7/11/19, identified a mechanical soft texture diet with thin liquids for mild dysphagia. R5's quarterly MDS dated 2/8/20, indicated he was severely cognitively impaired and ate independently after set up. R5's Clinical Physican's Order dated 12/20/17, identified a mechanical soft texture diet with thin liquids related to dysphagia. R6's admission MDS dated 4/12/20, indicated intact cognition and indicated he ate independently after set up. R6's Clinical Physican's Order dated 4/6/20, identified a	F 689	were delivered to the resident as ordered. Future resident admit diets will be reviewed prior to admission and verified by nursing. Dietary tickets will be printed and readily available for the dietary staff use. Nurse aide group sheets will be updated as needed for residents with therapeutic diets. Dietary manager was in-serviced on therapeutic diet policy and procedure. Nurse aides were educated on the update of their group sheet for residents who are on therapeutic diets. Dietary manager or designee is responsible for compliance. Audits on resident receiving the prescribed diet will begin 2x wk x3wks then monthly to ensure compliance. All audits will be reviewed by the administrator and taken to QAPI for review and recommendation. Compliance: 7/3/2020	

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F 689	Continued From page 6	F 689		

mechanical soft texture diet with thin liquids.

R7's quarterly MDS dated 1/15/20, indicated she was severely cognitively impaired and required extensive assistance from one staff to eat. R7's Clinical Physican's Order dated 3/13/20, identified a mechanical ground texture diet with thin liquids.

During interview on 5/2/20, at 8:43 a.m. the vice president of operations stated the facility was currently using dietary aides to prepare breakfast for the residents. She stated the facility had a cook coming in to prepare lunch and dinner. The vice president of operations stated the previous day the director of rehab helped with breakfast.

At 9:39 a.m. registered nurse (RN)-A stated she was not an employee of the facility and stated there were two nursing assistants (NA)'s on the unit. RN-A stated the two NA's were not regular facility staff and stated the facility had not provided any care sheets for the residents on the unit. RN-A stated she was not sure how the residents were getting their food.

RN-B stated this was his second day on the unit and stated he knew some of the patients but not all of them.

NA-A stated she had no guidance on how to care for the residents on the unit and stated the NA's were just checking and changing the residents.

On 5/4/20, at 10:22 a.m. the interim administrator stated the staffing levels were better than they had been over the weekend. The interim administrator stated he was trying to get extra staff to assist with hydration and food. The administrator further stated he was working on

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

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F 689	Continued From page 7 care guides to help staff identify diets. At 10:35 a.m. nurse practitioner (NP)-A stated she was working as a nursing assistant on the unit. NP-A stated, "I don't know who eats what kind of food." NP-A stated she was unable to find name cards or care guides. At 10:47 a.m. NA-B was assisting R4 to eat breakfast. NA-B stated he did not know R4's diet order and stated no diet slips had been provided. NA-B stated she had been giving the residents small bites of soft food and small sips of liquids. NA-B further stated thickened liquids had not been provided with the breakfast meal.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 15, 2020

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

Re: Event ID: FJ1411

Dear Administrator:

The above facility survey was completed on May 7, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

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 05/07/2020

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint investigation was conducted on 5/2/2020 to 5/7/2020, to investigate complaints H5289106C, H5289107C. No licensing orders were issued. The facility is enrolled in the electronic Plan of	2 000		

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

Electronically Signed | | 07/01/20

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	Continued From page 1 Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		