STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING _____ B. WING _____	05/07/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 (MDS) data set [DATE], 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. 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 [MEDICAL TREATMENT]. 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 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: 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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. Findings include: R1's quarterly Minimum Data Set ((MDS) dated [DATE], 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 [DATE], 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 [DATE], 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 [DATE], 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 [DATE], 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 [DATE], indicated intact cognition and indicated he ate independently after set up. R6's Clinical Physican's Order dated 4/6/20, identified a mechanical soft texture diet with thin liquids. R7's quarterly MDS dated [DATE], 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

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

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) on 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.