DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 0D7L

Facility ID: 00405

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245547**

2. STATE VENDOR OR MEDICAID NO. (L2) **292923000**

3. NAME AND ADDRESS OF FACILITY
(L3) **ADRIAN CARE CENTER**
(L4) **603 LOUISIANA AVENUE**
(L5) **ADRIAN, MN** (L6) **56110**

4. TYPE OF ACTION: 7 (L8)

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **10/01/2011**

6. DATE OF SURVEY **12/12/2014** (L34)

8. ACCREDITATION STATUS: __ (L10)

0 Unaccredited; 1 TJC; 2 AOA; 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. LTC PERIOD OF CERTIFICATION

From (a) :

To (b) :

12. Total Facility Beds **30** (L18)

13. Total Certified Beds **30** (L17)

10. THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:

___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:

__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	30			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS

1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :

Joseph Garvey, HFE NE II 01/06/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:

Kamala Fiske-Downing, Enforcement Specialist 01/30/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY

_X_ 1. Facility is Eligible to Participate

____ 2. Facility is not Eligible

(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21.
1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **02/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS

A. Suspension of Admissions: (L44)

B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00320** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **12/30/2014** (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN- 24-5547

On December 12, 2014, the Minnesota Department of Health completed a Post Certification Revisit to verify that this facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on October 30, 2014.

On Decmeber 29, 2014 the Minnesota Department of Public Safety conducted a revisit at the facility and found that the facility was in substantial compliance. Based on the period of time the facility was not in substantial compliance, the following remedies will remain for the period of time listed:

State Monitoring, effective November 22, 2014 through December 8, 2014
Federal Civil Money Penalty of $3,650.00 per day for the one (1) day, October 29, 2014. (42 CFR 488.430 through 488.444)

Federal Civil Money Penalty of $100.00 per day for the thirty-nine (39) days beginning October 30, 2014 and continuing through December 7, 2014 for a total of $3,900.00. (42 CFR 488.430 through 488.444)

The facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs
(NATCEP) for two years from October 30, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b).

Please refer to the CMS 2567b.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245547

January 29, 2015

Ms. Dorothy Baker, Administrator
Adrian Care Center
603 Louisiana Avenue
Adrian, Minnesota 56110

Dear Ms. Baker:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 8, 2014 the above facility is certified for:

30 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 30 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

January 23, 2015

Ms. Dorothy Baker, Administrator
Adrian Care Center
603 Louisiana Avenue
Adrian, Minneosta 56110

RE: Project Number F5547024

Dear Ms. Baker:

On November 17, 2014, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective November 22, 2014. (42 CFR 488.422)

On December 12, 2014, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on October 30, 2014.

On Decmeber 29, 2014 the Minnesota Department of Public Safety conducted a revisit at your facility and found that your facility was in substantial compliance.

On January 22, 2015, based on your facility being in compliance, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies will not go into effect:

Mandatory denial of payment for new Medicare and Medicaid admissions, which was to be effective January 30, 2015.

Mandatory termination of your Medicare and Medicaid provider agreements, which was to be effective April 30, 2015.

However, based on the period of time your facility was not in substantial compliance, the following remedies will remain in effect:

State Monitoring, effective November 22, 2014 through December 8, 2014

Federal Civil Money Penalty of $3,650.00 per day for the one (1) day, October 29, 2014. (42 CFR 488.430 through 488.444)

> Federal Civil Money Penalty of $100.00 per day for the thirty-nine (39) days beginning October 30, 2014 and continuing through December 7, 2014 for a total of $3,900.00. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an extended survey completed on October 30, 2014. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 8, 2014.

However, as we notified you in our letter of November 17, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 30, 2014.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245547	A. Building B. Wing	12/12/2014

Name of Facility	Street Address, City, State, Zip Code
ADRIAN CARE CENTER	603 LOUISIANA AVENUE ADRIAN, MN 56110

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0241** Reg. # **483.15(a)** LSC	**12/08/2014**	ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	**12/08/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	**12/08/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**12/08/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	**12/08/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	**12/08/2014**
ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	**12/08/2014**	ID Prefix **F0334** Reg. # **483.25(n)** LSC	**12/08/2014**	ID Prefix **F0497** Reg. # **483.75(e)(8)** LSC	**12/08/2014**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/KFD	01/06/2015	03048	12/12/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/30/2014			

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245547	A. Building B. Wing **01 - MAIN BUILDING 01**	12/29/2014

Name of Facility	Street Address, City, State, Zip Code
ADRIAN CARE CENTER	603 LOUISIANA AVENUE ADRIAN, MN 56110

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0029	Correction Completed **11/03/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** PS/KFD	**Date:** 01/23/2015	**Signature of Surveyor:** 34764	**Date:** 12/29/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 10/28/2014		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245547	A. Building B. Wing 02 - 2009 LINK TO ASSISTED LIVING	12/29/2014

Name of Facility	Street Address, City, State, Zip Code
ADRIAN CARE CENTER	603 LOUISIANA AVENUE ADRIAN, MN 56110

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	11/03/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/KFD	01/23/2015	34764	12/29/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/28/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 0D7L
Facility ID: 00405

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245547**

2. STATE VENDOR OR MEDICAID NO.
(L2) **292923000**

3. NAME AND ADDRESS OF FACILITY
(L3) **ADRIAN CARE CENTER**
(L4) **603 LOUISIANA AVENUE**
(L5) **ADRIAN, MN** (L6) **56110**

4. TYPE OF ACTION: **2** (L8)

1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **10/01/2011**

6. DATE OF SURVEY **10/30/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **30** (L18)

13.Total Certified Beds **30** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:

__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	30			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Joseph Garvey, HFE NE II 12/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/30/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
02/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3055 4996

November 17, 2014

Mr. Scott Kessler, Administrator
Adrian Care Center
603 Louisiana Avenue
Adrian, Minnesota 56110

RE: Project Number S5547024

Dear Mr. Kessler:

On October 30, 2014, an extended survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;**
>
> **<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;**
>
> **<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);**
>
> **<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;**
>
> **<u>Appeal Rights</u> - the facility rights to appeal imposed remedies;**

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on October 30, 2014, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Kathryn.serie@state.mn.us
Office: (507) 476-4233
Fax: (507) 537-7194

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective November 22, 2014. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F323, (42 CFR 488.430 through 488.444).

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended survey as a result of a finding of substandard quality of care. Therefore, Adrian Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 30, 2014. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

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

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The

DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC 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 remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC 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 PoC 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 PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 January 30, 2015 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 30, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245547	A. BUILDING ______ B. WING ______	10/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADRIAN CARE CENTER	603 LOUISIANA AVENUE ADRIAN, MN 56110

(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 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable 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. A recertification survey was conducted by the Minnesota Department of Health on 10/27, 10/28, 10/29 and 10/30/14. An extended survey was conducted. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failure to provide assessment and appropriate interventions to prevent injury related to unsafe smoking practices for R3, which resulted in a high potential for harm or death. On 10/29/14, facility staff were notified of the IJ which began on 4/9/14. The IJ was removed on 10/30/14, at 11:30 a.m., however non-compliance remained at the lower scope and severity level of a D, isolated, with no actual harm with a potential for no more than minimal harm.	F 000	approved KMS 12/1/14 all plan of correction date changed to 12/8/14 per telephone Dorothy Baker, adm. on 12/1/14 @ 12 noon	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dorothy Baker
TITLE: Administrator
(X6) DATE: 11-26-14

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 241	Continued From page 1 by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 1 of 26 residents (R21) who received meals from the dining room, who expressed irritation about the lack of timeliness of the meal service. Findings include: The annual Minimum Data Set (MDS) assessment, dated 8/13/14 identified that R21 had a brief interview for mental status (BIMS) score of 15, indicating intact cognition. The MDS further identified that R21 did not exhibit any behavioral symptoms. During observation of the evening meal on 10/28/2014, at 5:05 p.m. R 21 was seated at a table in the main dining room. It was noted at 5:16 p.m. that R21 remained seated at the table with her head on her hands, shaking her head. At 5:27 p.m. R21 stood up from the table and walked out of the dining area. According to the scheduled meal times, although the supper meal was scheduled to be served at 5:00 p.m., staff had not yet started to serve the dinner trays. After R21 left the dining area, R21 was observed sitting in a recliner in her room watching television at 5:30 p.m. When questioned whether R21 was going to return to the dining room, R21 stated, "I'm tired of this, they tell us to come for supper and we sit there and wait. They are supposed to serve at 5:00 p.m. Do you see what time it is and they haven't started. It makes me nervous. They are never on time. I don't know if I will go back or not." R21 stated she didn't know why staff always came to her room and encouraged her to	F 241	**F 241** 1. R21 has been monitored for her meal service times and has expressed satisfaction with the current wait time especially in the evening. 2. All resident meal serving times are being monitored for timeliness. 3. Meal serving procedures have been reviewed and revised to assure all resident are served meals within 15 minutes of being seated. Audits of resident meal service will be done daily X 5 days, continuing to 3 X a week for 14 days and at least weekly thereafter or until 100% compliance is achieved. 4. All staff will be educated on the meal serving protocols on Dec 2, 2014. 5. Administrator will monitor the serving and audit process. Summary Data shall be presented to the QAA committee.	~~12-24-14~~ 12-8-14

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F 241	Continued From page 2 go for supper at 5:00 p.m. when the supper meal was always served late. During continued observation of the supper meal on 10/28/14, the first tray was served in the dining room at 5:32 p.m. At 5:56 p.m. staff returned to R21's room and informed her supper was being served. R21 ambulated back to the dining room and received her supper tray at 6:00 p.m.. During further interview on 10/28/14, at 6:25 p.m. R21 stated, "The food was okay but I'm sick and tired of waiting to be served my supper meal. It is always later than it is supposed to be." R21 stated she did not feel like staff really cared about the residents' time.	F 241		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide activities to meet the individual needs for 3 of 3 cognitively impaired residents, (R4, R19 and R1) who were reviewed for activities. Findings include: R4 was admitted on 8/31/11, and the annual	F 248	F 248 1. R4, R19, & R1 will be re-assessed for their activity preference and their care plans will be reviewed & revised to reflect these preferences. 2. All residents will have an "Activity Preference" sheet developed reflecting their individual preferences as well as a summary sheet for staff reference for all residents'' preferences. All resident care plans will reflect these individual resident preferences. Additionally, attendance logs shall be maintained reflecting the patterns of an individual resident's attendance to an activity.	

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F 248	Continued From page 3 Minimum Data Set (MDS) assessment dated 8/1/14 indicated the resident had diagnoses which included depressive disorder and senile dementia. R4 annual MDS assessment dated 8/1/14, identified that R4 required extensive assistance of staff with all activities of daily living (ADL's), and that he had severe cognitive impairment. R4 was usually understood but had difficulty communicating some words or finishing thoughts, but able when prompted or given time. The MDS also identified that it was somewhat important for R4 to have the following activities: newspapers, books, magazines to read, to listen to music he enjoys, to keep up with the news, participate with groups of people, attend favorite activities, go outside when the weather is nice and participate in religious activities. R4 was observed throughout the survey from 10/27/14 to 10/30/14 and there were no observations of participation in any organized activities. During observation of an activity conducted in the dining room on 10/28/14, at 2:40 p.m. it was noted that R4 remained in his room lying on the bed. On 10/28/14, at 4:43 p.m. R4 remained seated in the lobby located near the nurse's station, sleeping in front of the television. A birthday party with snacks was observed to be held on 10/29/14 at 3:20 p.m. and R4 remained in his room, not involved in the activity provided. Review of the care plan dated 9/20/14, indicated	F 248	3. Activity protocols will be developed to reflect recreational programming. Staff will be educated on the expectations of Administration for the psychosocial well-being of residents. 4. Administrator or designee will implement audits to monitor resident attendance in scheduled activities and resident attendance at activities reflects the resident's preference. Audits will be conducted daily X7 days, then 3X/week for 14 days and thereafter, at least weekly for 30 days. 5. Cumulative data collected from audits shall be presented to the QAA Committee for review &/or comment.	12-~~24~~ 8-14

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F 248	Continued From page 4 R4 was involved in activities only a little amount of time when awake. The goal for R4 included attendance at morning activities at least 4 times per week. The care plan identified that R4 enjoyed talking about past history of hunting, fishing and trapping, and indicated materials of interest should be provided which would include newspapers and magazines as he sometimes reads materials depending on his mood. The care plan also indicated R4 should be encouraged to become involved with activities such as exercises, bingo, church services, music and newspapers. R19 was admitted 5/25/12 with diagnoses including Parkinson's disease, dementia and depressive disorder as indicated on a cummulative diagnoses list in the medical record. A quarterly MDS assessment dated 10/9/14, identified that R19 required extensive assistance from staff with all ADL's and had cognitive impairment. In addition, the MDS indicated the resident was unable to answer questions, had difficulty communicating some words or finishing thoughts, but was able when prompted or given time. The MDS also identified the following activities as somewhat important for R19: books, magazines, newspapers to read, listen to music, be around pets, keep up with the news, be around groups of people and participate in religious services. Documentation indicated it was very important for R19 to do her favorite activities and go outside in good weather. R19 was observed throughout the survey from 10/27/14 to 10/30/14 and there were no observations of participation in any organized activities.	F 248		

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F 248	Continued From page 5 During observation of resident on 10/27/14, at 2:00 p.m. the resident was observed to be sleeping in bed. During observation of the activity conducted in the dining room on 10/28/14, at 2:40 p.m. it was noted that R19 remained in bed. During observation on 10/28/14, at 4:43 p.m. R19 was seated in the main lobby facing away from the television, and was yelling out. During observation of the facility's birthday party activity on 10/29/14 at 3:20 p.m., R19 was observed to remain in her room, without encouragement to participate in the activity. R19's care plan dated 12/11/12, identified a problem of lack of activity involvement due to R19 only being involved in activities 1/3 or less of the time related to Parkinson's Disease. The long term goal identified that R19 would report participation in a satisfying activity program. The approaches to meet this goal were identified as adjusting the intensity, frequency and/or duration of activities to accommodate the resident's energy level and tolerance, and to praise R19 when involved. During interview on 10/29/14, at 1:55 p.m. the director of nursing (DON) stated the administrator was in charge of activities. The DON stated she did not think staff documented resident activity involvement, and stated she was unaware of where the activity documentation would be kept in the medical record as the former activity staff no longer worked in the facility. R1 was admitted on 1/2/14 and had diagnoses of	F 248		

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F 248	Continued From page 6 anemia and Alzheimer's disease. R1 was noted to have difficulty communicating his preferences and demonstrated considerable debilitation. The quarterly Minimum Data Set (MDS) assessment, dated 7/12/14, identified that R1 required extensive assistance of staff with all ADLs and had modified independence with decision making. R1 was observed throughout the survey from 10/27/14 to 10/30/14 and there were no observations of participation in any organized activities. During observation on 10/27/14, at 2:23 p.m. an activity was conducted in the dining room. While the activity was held, R1 was observed lying on his bed. During interview on 10/28/14, at 3:35 p.m. nursing assistant (NA)-D stated that exercise and massage activities were offered and only 1 resident attended. NA-D stated R1 did not attend the scheduled activity and confirmed there were no further activities scheduled for the day. A birthday party with snacks was held on 10/29/14, at 3:30 p.m. and it was noted that R1 remained in his room and did not participate. During interview on 10/29/14, at 3:45 p.m. the DON was asked whether an activity preference assessment or activity log was available for review. The DON stated the administrator was acting as the activity director and she was unable to produce the requested information. The DON stated she was aware the activity staff who no longer worked at the facility, had not been completing activity care plans. The DON further indicated on 10/29/14, at 4:11 p.m. that activity care plans had not been completed by the previous activity director and therefore R1 had no	F 248		

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F 248	Continued From page 7 activity care plan developed. During interview with the administrator on 10/29/14, at 4:00 p.m. it was verified there were no activity logs available nor was he aware of any preference assessment for residents. The administrator state the previous activity staff no longer worked at the facility and that social service staff assisted with activities three days a week or otherwise nursing staff would conduct activities. The administrator verified there were no one to one activity programs implemented with any residents but stated residents were wheeled out to the day room to watch television and socialize.	F 248		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	F 279 1 R19 has been reassessed for skin issues in the medical record. R1's plan of care has been reviewed and revised to reflect activity preferences. 2. **Skin Issues:** All residents are to receive a comprehensive skin observational assessment on a weekly basis. The observational review is to be conducted by a nurse, graphically outlining the issue with measurements and attempts to discern the root cause of the issue. The residents care plan will have interventions to minimize further issues. **Activities:** See F248 for activity protocols.	

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F 279	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop care plan approaches for 1 of 3 residents (R19) reviewed who had non pressure related skin conditions and for 1 of 3 residents (R1) reviewed for activity involvement. Findings include: R19 was noted to have dark purple areas as well as darkened skin on her hands and arms that were not identified on the care plan. The Minimum Data Set (MDS) for R19 identified diagnoses which included Parkinson's disease and tremors. The care plan edited 9/20/14, noted the resident was at risk for pressure ulcers related to immobility with a goal for residents skin to remain intact. Staff were instructed to report any signs of skin breakdown (sore, tender, red, or broken areas). It was observed on 10/27/14, at 1:40 p.m. that R19 had darkened skin areas on her forearms and on the top surface of her hands. Purple/reddish colored areas were located on her face and neck, with a discolored area above the right eye. The areas located on the top of her hands were dark brown in color. R19 had a dark purple area located on the right wrist which was approximately 2.5 centimeters (cm) long and 1.5 cm wide. It was noted there were dark brown areas of discoloration on the right arm. The left arm had 3 dark purple circular spots located on the mid- forearm area, approximately 1 cm. in	F 279	3. **Skin:** Audits to assure weekly skin assessments are completed shall be ongoing every week until 100% compliance is obtained. Follow-up to the weekly skin assessments shall be performed by the DON or designee to confirm accurate information is being recorded on the skin assessment sheet **Activities** : See F248 for all activities protocols. 4. All staff will be educated on the skin & activities protocols on Dec 2, 2014. 5. All audit outcomes shall be reported to the QAA Committee for review & comment.	12-~~24~~8-14

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(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 279	Continued From page 9 size.	F 279		

Review of the care plan edited 9/20/14 identified the resident at risk for pressure ulcers but did not address the many areas of skin discoloration and lacked any interventions.

During interview with the director of nursing (DON) on 10/30/14, at 9:24 a.m. she stated the identified areas were not bruises, but R19 has fragile skin. The DON verified she was aware of the skin discolorations but they had never been identified nor monitored as part of the care plan.
R1 was admitted on 1/2/14 and had diagnosis of Alzheimers disease. R1 was noted to have difficulty communicating preferences. The quarterly Minimum Data Set (MDS) assessment, dated 7/12/14, identified that R1 required extensive assistance of staff with all activities of daily living (ADLs) and had modified independence with decision making.

R1 was observed throughout the survey from 10/27/14 to 10/30/14 and there were no observations of participation in any organized activities. During observation on 10/27/14, at 2:23 p.m. an activity was conducted in the dining room. While the activity was held, R1 was observed lying on his bed. During interview on 10/28/14, at 3:35 p.m. nursing assistant (NA)-D stated that exercise and massage activities were offered and only 1 resident attended. NA-D stated R1 did not attend this scheduled activity and confirmed there were no further activities scheduled for the day.

A birthday party with snacks was held on 10/29/14, at 3:30 p.m. and it was noted that R1 remained in his room and did not participate.

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F 279	Continued From page 10 During review of R1's record and care plan it was noted the care plan lacked any problem, goals or interventions related to activity involvement. During interview on 10/29/14, at 3:45 p.m. the director of nursing (DON) was asked whether an activity care plan was available for review. The DON stated she was aware the activity staff who no longer worked at the facility, had not been completing activity care plans. The DON further indicated on 10/29/14, at 4:11 p.m. that activity care plans had not been completed by the previous activity director and therefore R1 had no activity care plan developed.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide interventions as directed by the plan of care for 1 of 1 resident (R3) who routinely smoked outside the building without supervision and failed to implement the plan of care for 2 of 3 residents (R4 and R19) reviewed for activity involvement. Findings include: R3 was admitted on 7/13/11 and had diagnoses listed on his active physician orders that included:	F 282	F282 1. R4, R19 Care plan have been reviewed & revised and remain current. 2. All residents that smoke have had a smoking assessment. Based on this assessment, smoking interventions were implemented as needed. All resident care plans have been reviewed & revised as needed. Please see F248 for activity protocols. 3. All staff have been educated on the need to follow the resident's plan of care and any updated changes to facility protocols. For smoking residents, DON or designee shall conduct daily audits for 7 days, then audit 3 X a week until 100% compliance achieved. 4. All audit outcomes will be presented to the QAA committee for comment & review.	12-~~24~~ 8-14

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diabetes, polyneuropathy, blindness, narcolepsy, schizophrenia, cellulitis, depression, and acute renal failure. The plan of care identified that a walkie-talkie would be provided for R3 when outside smoking and that staff would provide supervision.

The care plan dated 11/22/13, identified that R3 smoked cigarettes in the court yard in front of the facility 2-3 x (times) daily and was unable to smoke independently. The care plan also identified that R 3 was totally blind and had been a cigarette smoker most of his life; however, a recent diagnosis of narcolepsy had made it difficult for R3 to continue to smoke independently without supervision. Symptoms related to the sleep disorder (narcolepsy) could be exhibited as periods of extreme daytime sleepiness and sudden, irresistible bouts of sleep that can strike at any time. Documentation on the care plan indicated R3 had not burned himself or equipment due to carelessness and that R3 was supervised by staff and often checked on, in case he fell asleep while smoking. The care plan indicated R3's blindness did not have an impact on his safety but the diagnosis of narcolepsy did impact his safety. Interventions were listed as having a walkie-talkie with him when outside and staff supervision.

During observation on 10/29/14, at 9:40 a.m. R3 was seated outside in the wheelchair, smoking alone. R3 had multiple burn holes on his coat and was located outside the dining room door. It was noted on 10/29/14, at 9:45 a.m. that R3 knocked on the dining room window in an attempt to alert staff that required assistance to re-enter the building. After repeated knocking, dietary staff (DS)-A responded to the noise and opened

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the dining room door to the outside of the building and assisted R3 back into the building. No staff were in the area to monitor R3 while he was smoking alone outside.

On 10/29/14, 1:15 p.m. an attempt was made by the surveyor, to further interview R3 but he was unable to be located within the building. At 1:18 p.m. knocking on the dining room window was heard by the surveyor, but the location of R3 was unable to be visualized as the curtain/drape was pulled over the window. R3 had been smoking outdoors, adjacent to the dining room and was not visible from the inside of the building. When the outside door was opened by the surveyor, R3 was noted to have cigarette ashes on his coat, pants and wheelchair. There was a hole in the coat where a large amount of the ashes were present but it was difficult to ascertain whether the burn hole was new or whether it had occurred from a prior smoking incident. It was noted that R3 had a walkie-talkie in his hand but he indicated it was not working. When staff were finally located and requested to assist R3 at 1:35 p.m.(17 min. later), NA-A indicated she was unaware R3 had left the building to have a smoke but would help him return inside.

During interview with certified nursing assistant (NA)-D on 10/29/14, at 11:16 a.m. she stated she had witnessed R3 fall asleep 1-2 times while smoking. NA-D stated staff were supposed to monitor R3 while outside smoking but there was not enough staff available to provide this supervision.

During an interview on 10/29/14, at 1:41 p.m. NA-A stated she was unsure whether R3 fell asleep at times when smoking and reiterated that

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staff were supposed to supervise R3 but there was not enough staff available.

During interview on 10/29/14, at 3:40 p.m. NA-B stated R3 was not supervised because there is not enough staff to supervise him while smoking outside.

During interview on 10/29/14, at 2:30 p.m. registered nurse (RN)-C stated she was aware that staff R3 was not always supervised and monitored during smoking as the staff are always busy and he spent a lot of time outside smoking.

During interview on 10/29/14, at 10:54 a.m. the director of nursing services (DON) stated R3 was supposed to have an operational walkie-talkie when outside smoking to notify staff when he wanted to re-enter the facility. The DON confirmed the care plan had not been followed as there was not have enough staff to provide continuous supervision of R3 while he smoked.
R4 was admitted on 8/31/11 and the Minimum Data Set (MDS) assessment identified diagnoses which included depressive disorder and senile dementia.

Review of the care plan dated 9/20/14 indicated that R4 was involved in activities little of the time while awake. The goal for R4 was identified as: attend morning activities at least 4 times per week. The care plan identified that R4 enjoyed talking about past history of hunting, fishing and trapping and the facility would provide materials of interest including newspapers and magazines as he sometimes reads materials depending on mood. It also indicated that R4 would be encouraged to become involved with activities identified as exercises, bingo, church services,

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music, newspapers. The plan of care was not followed to provide morning activities at least 4 times/week.

R4 was observed throughout the survey from 10/27/14 thru 10/30/14 and was not observed to participate in any activities. During observation of resident on 10/28/14, at 2:40 p.m. the facility staff was conducting an activity in the dining room. During the activity R4 was observed to be lying in bed.

On 10/28/14 at 4:43 p.m. resident was sitting out in the lobby in front of the television, sleeping.

On 10/29/14, at 3:30 p.m. R4 was not observed in activities. A birthday party with snacks was held at 3:20 p.m. and R4 remained in his room.

R19 was admitted 5/25/12 with diagnoses identified in the medical record which included Parkinson's disease, dementia and depressive disorder.

Review of the care plan dated 12/11/12 identified that lack of activity involvement was a problem due to R19 only being involved in activities 1/3 or less of the time related to Parkinson's Disease. The long term goal identified that R19 would report participation in a satisfying activity program. The approaches to meet this goal were identified as adjusting the intensity, frequency and/or duration of activities to accommodate the resident's energy level and tolerance and to praise R19 when involved.

R19 was observed throughout the survey from 10/27/14 to 10/30/14 and there were no observations of participation in any organized

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F 282	Continued From page 15 activities. During observation of resident on 10/27/14, at 2:00 p.m. the resident was not observed in any type of activity, she was sleeping in bed. During observation of the activity conducted in the dining room on 10/28/14, at 2:40 p.m. it was noted that R19 remained in her room lying on the bed. It was observed on 10/28/14, at 4:43 p.m. that R19 was seated in the main lobby facing away from the television, yelling out. A birthday party with snacks was held on 10/29/14 at 3:20 p.m. and R19 remained in her room, not involved in the activity provided. During interview on 10/29/14, at 1:55 p.m. the director of nursing (DON) verified the care plans had not been followed. She stated the administrator was in charge of activities. She stated that no one tracks whether a resident attends activities, as there are no logs of attendance. During interview with the administrator on 10/29/14, at 4:00 p.m. it was verified there was no activity logs available and the social service staff assisted with activities three days a week or otherwise nursing staff would conduct activities. The administrator verified there were no 1 to 1 (one to one) activity programs implemented with any residents but stated residents were wheeled out to the day room to watch television and socialize.	F 282		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/17/2014
FORM APPROVED
OMB NO. 0938-0391

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F 309 SS=D	Continued From page 16 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify and monitor non pressure related skin issues for 1 of 3 residents (R19) reviewed who had non pressure related skin conditions. Findings include: It was observed on 10/27/14, at 1:40 p.m. that R19 had darkened skin areas on her forearms and on the top surface of her hands. Purple/reddish colored areas were located on her face and neck, with a discolored area above the right eye. The areas located on the top of her hands were dark brown in color. R19 had a dark purple area located on the right wrist which was approximately 2.5 centimeters (cm) long and 1.5 cm wide. It was noted there were dark brown areas of discoloration on the right arm. The left arm had 3 dark purple circular spots located on the mid- forearm area, approximately 1 cm. in size. The Minimum Data Set (MDS) for R19 identified diagnoses which included Parkinson's disease and tremors. The care plan edited 9/20/14, noted	F 309	F309 1. R 19 has been reassessed for skin issues. 2. All residents are to receive a comprehensive skin observational assessment on a weekly basis. The observational review is to be conducted by a nurse, graphically outlining the issue with measurements and attempts to discern the root cause of the issue. The residents care plan will have interventions to minimize further issues. 3. Audits to assure weekly skin assessments are completed shall be ongoing every week until 100% compliance is obtained. Follow-up to the weekly skin assessments shall be performed by the DON or designee to confirm accurate information is being recorded on the skin assessment sheet weekly.. 4. All staff will be educated on the skin & activities protocols on Dec 2, 2014. 5. All audit outcomes shall be reported to the QAA Committee for review & comment.	12-~~24~~ 8-14

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F 309	Continued From page 17 the resident was at risk for pressure ulcers related to immobility with a goal for residents skin to remain intact. Staff were instructed to report any signs of skin breakdown (sore, tender, red, or broken areas). The medical record identified that R19 received aspirin 81 milligrams per day which can increase risk for bruising. Documentation was lacking on the weekly skin assessment documents from January 2014 to the present (October) to indicate the discolored areas were monitored and/or identified. During interview on 10/30/14, at 9:24 a.m. the director of nursing (DON) stated the identified areas were not bruises, but that R19 has fragile skin. The DON verified she was aware of the skin discolorations but acknowledged the areas had never been formally identified or monitored.	F 309		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and 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 supervision and appropriate interventions to prevent the risk of injury related to unsafe smoking for 1 of 1 resident reviewed (R3), who smoked outside the building, had multiple burn holes evident on his	F 323	F323 1. Adrian Care Center will continue to support the philosophy of Person-Centered Care. However, will assess the resident's ability to make smoking decisions without harm to self or others. The LSW will acquire a means to measure the resident's cognition. The charge nurse will complete a smoking observation quarterly on all residents that smoke, any changes will be reported to the DON. The DON will implement interventions as needed to each individuals needs to provide safety to all involved.	

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F 323	Continued From page 18 clothing and wheelchair and who experienced a condition (narcolepsy) in which periods of extreme daytime sleepiness and sudden, irresistible bouts of sleep that can strike at any time was present. The potential risk of serious harm or injury was determined to place R3 in immediate jeopardy (IJ). The IJ began on 4/9/14, when R3 was diagnosed with narcolepsy which placed him at increased risk for falling asleep while smoking. The administrator was informed of the immediate jeopardy (IJ) at 2:30 p.m., on 10/29/14. The immediate jeopardy was removed on 10/30/14, but noncompliance remained at the lower scope and severity level of D-isolated scope and severity with no actual harm, with potential for more than minimal harm that is not immediate jeopardy. Findings include: R3 had been assessed and identified as at moderate risk for safety when smoking and staff were aware of burn holes to his clothing/coat and wheelchair. In addition, R3 had been diagnosed with a sleep disorder in April 2014. Although staff acknowledged that R3 was not supervised when smoking, the facility failed to assess, monitor and implement interventions to assure R3's safety and to reduce the risk of serious harm or injury. R3 was admitted on 7/13/11. The diagnoses listed on the current physician orders included: diabetes, polyneuropathy (loss of feeling), blindness, narcolepsy, schizophrenia, cellulitis, depression, and acute renal failure. During observation on 10/29/14, at 9:40 a.m. R3 was noted to smoke cigarettes outside the facility	F 323	2. Adrian Care Center has implemented checks for Resident EK which are documented on the Resident Monitoring form and his care plan and care sheets. The resident has a Narcolepsy diagnosis and is unsafe smoking unless supervised. Interventions have been implemented to include supervision each time he smokes by staff and the resident will wear a smoking apron each time he smokes. The Charge Nurse will monitor for completion of documentation by staff. If injury occurs and if it is determined to be a reportable event to OHFC, that report will also be made. 4. The resident's care plan will be updated to reflect his individually assessed needs. All staff will be educated/informed on this situation. This subject will be part of our yearly in-services provided to maintain up keep and ensure compliance for safe smoking. 5. The resident's care plan will be re-assessed weekly for 4 weeks, and then monthly thereafter for 6-months. After 6-months, the plan will be reviewed quarterly as is standard for all residents' care plans.	

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F 323	Continued From page 19 dining room and had multiple burn holes located on his coat. R3 was alone outside and without direct staff supervision. On 10/29/14, at 9:45 a.m. R3 was observed to knock on the dining room window in an attempt to alert staff that he needed assistance to re-enter the building. After multiple knocks on the window, dietary staff (DS)-A who was located in the dietary kitchen, directly adjacent to this dining area but separated by a closed door, heard the repeated knocking exhibited by R3. DS-A responded by opening the outside door in the dining room and assisted R3 back into the building. During interview on 10/29/14, at 11:20 a.m. R3 stated he would fall asleep at times when outside smoking and confirmed that sometimes other residents would yell at him when he started to fall sleep. R3 also verified he was frequently alone when outside smoking. During the interview R3's coat was observed lying on his bed. The coat had multiple burn holes of different sizes, none of which were larger than dime size. It was observed that some of the burn holes had melted the outer fabric of the coat and exposed the inside filling of the coat. It was further noted there were several (approximately 5) burn holes located on the inside lining of the coat, which indicated that hot cigarette ashes had dropped into the inside lining of the coat. Burn holes/spots were also evident on the armrest and seat of the wheelchair, which R3 had used since 4/9/14 after he had been newly diagnosed with narcolepsy (condition in which periods of extreme daytime sleepiness and sudden, irresistible bouts of sleep that can strike at any time). Upon request to inspect his clothing, R3 consented and it was noted that R3 had 4 shirts in his closet with burn holes. When questioned about the burn holes, R3	F 323	6. For other residents that smoke a complete review of cognition, care plan, and interventions will be completed by the Interdisciplinary Care Team. Revisions will be completed as needed. 8. Meetings will be held with nursing staff informing them of the plan as described above. Written copies of the same information were provided to all departments to be posted for staff who did not attend the meetings. Education will be provided charge nurse by DON in shift change and the charge nurse will be responsible to ensure the staff on at that time implement the interventions for safe smoking. 9. The Ombudsman will be contacted for further support for this resident and other residents who have a similar profile if needed. Adrian Care Center recognizes that the Ombudsman may have other ideas as how to balance safety with quality of life that we have not thought of in the writing of this plan.	

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F 323	Continued From page 20 stated he was not worried about the burn holes as he occasionally dropped cigarettes ashes on himself/clothing. When questioned about his need for assistance to gain access into the building after he had finished smoking, he stated that sometimes it took staff a long time to come and open the door. R3 stated he bangs on the window to alert staff as the walkie-talkie provided him, frequently did not work. R3 expressed that he wished staff would always remember to turn the device on and/or demonstrate how to use it. R3 stated that he was unable to turn the walkie-talkie on when staff had forgotten since he was unable to visualize the controls (due to blindness). On 10/29/14, at 1:15 p.m. an attempt was made by the surveyor, to further interview R3 but he was unable to be located within the building. At 1:18 p.m. knocking on the dining room window was heard by the surveyor, but the location of R3 was unable to be visualized as the curtain/drape was pulled over the window. R3 had been smoking outdoors, adjacent to the dining room and was not visible from the inside of the building. When the outside door was opened by the surveyor, R3 was noted to have cigarette ashes on his coat, pants and wheelchair. There was a hole in the coat where a large amount of the ashes were present but it was difficult to ascertain whether the burn hole was new or whether it had occurred from a prior smoking incident. It was noted that R3 had a walkie-talkie in his hand but he indicated it was not working. When staff were finally located and requested to assist R3 at 1:35 p.m.(17 min. later), NA-A indicated she was unaware R3 had left the building to have a smoke but would help him return inside.	F 323	1. R4, R19 Care plan have been reviewed & revised and remain current. 2. All residents that smoke have had a smoking assessment. Based on this assessment, smoking interventions were implemented as needed. All resident care plans have been reviewed & revised as needed. Please see F248 for activity protocols. 3. All staff have been educated on the need to follow the resident's plan of care and any updated changes to facility protocols. For smoking residents, DON or designee shall conduct daily audits for 7 days, then audit 3 X a week until 100% compliance achieved. 4. Staff will be educated on Dec. 2, 2014 as to the plan to provide safe smoking for our residents. 5. All audit outcomes will be presented to the QAA committee for comment & review.	12-~~24~~ 8-14

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	245547	A. BUILDING ________ B. WING ________	10/30/2014

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F 323	Continued From page 21	F 323		

Continued From page 21

During interview with R10 on 10/29/14, at 3:30 p.m. R10 stated she had observed R3 fall asleep while smoking and had yelled at him awaken. R10 stated she had hollered out R3's name when he appeared to have his eyes closed to make sure he was not sleeping. R10 indicated she couldn't tell for sure whether he was asleep or not as he sometimes kept his eyes closed. R10 also stated she had been asked by staff on occasion to watch R3 while he smoked but replied that it was not her job. R10 commented that she did not think R3 was safe smoking alone.

On 9/14/14, a smoking risk assessment was conducted and it indicated R3 had a moderate problem with carelessness relative to smoking materials. The section titled (Drops cigarette/cigar butts or matches on floor, furniture, self, or others; burns finger tips) was documented as a moderate problem. The assessment summary identified that R3 smoked in the court yard by the window so he could be observed by staff and that a walkie-talkie was provided so he could alert staff when he finished smoking.

The care plan, dated 11/22/13, identified that R3 smoked cigarettes in the court yard located in front of the facility two (2)- three (3) times daily. Documentation indicated R3 was unable to smoke independently in the court yard as R3 was totally blind. Revised care plan documentation indicated R3 had been a cigarette smoker most of his life but the recent diagnosis of narcolepsy had made it difficult for R3 to smoke independently. R3 was identified as compliant with smoking protocols and required staff assist to locate the designated outdoor smoking area and orientation to the receptacles and seating

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F 323	Continued From page 22 area. The care plan further identified that R3 enjoyed sitting outdoors in good weather, having several cigarettes over the course of time. It identified R3 as safe in handling his own smoking materials. The care plan documentation indicated R3 had not burned himself nor equipment due to carelessness but that staff watched and often checked R3, in case he fell asleep while smoking. It was also documented that other residents would go outside and call his name if he had fallen asleep while smoking. The care plan indicated R3's blindness did not have an impact on his safety but the diagnosis of narcolepsy did impact his safety. Interventions listed were: provide with a walkie-talkie when outside and staff supervision. During interview with the director of nursing services (DON) on 10/29/14, at 10:54 a.m. she stated R3 was supposed to have a walkie-talkie when outside smoking to notify staff when he wanted to re-enter the facility. The DON stated sometimes other residents would see R3 falling asleep while outside and would awaken him. She confirmed that staff were directed to monitor R3 while smoking, but that did not always occur as she did not have enough staff to provide continuous supervision of R3 when he smoked. The DON confirmed that although R3 was a burn risk while smoking, he had not yet burned himself. During interview with certified nursing assistant (NA)-D on 10/29/14, at 11:16 a.m. she stated she had witnessed R3 fall asleep 1-2 times while smoking. NA-D stated staff were supposed to monitor R3 while outside smoking but there was not enough staff available to provide this supervision.	F 323		

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F 323	Continued From page 23	F 323		

During an interview on 10/29/14, at 1:41 p.m. NA-A stated she was unsure whether R3 fell asleep at times when smoking and reiterated that staff were supposed to supervise R3 but there was not enough staff available.

During interview on 10/29/14, at 3:40 p.m. NA-B stated R3 was not supervised because there is not enough staff to supervise him while smoking outside.

During interview on 10/29/14, at 2:30 p.m. registered nurse (RN)-C stated she was aware that staff R3 was not always supervised and monitored during smoking as the staff are always busy and he spent a lot of time outside smoking. She indicated that she felt R3 was at risk for burning himself.

When questioned on 10/29/14, at 3:55 p.m. whether there were any incidents related to burns for R3, the DON verified there were no incidents related to burning himself and/or clothing. The DON confirmed she was aware of the burn holes located on R3's coat and wheelchair, which had only been utilized since 4/9/14. The DON again verified that R3 was at risk for being burnt while smoking cigarettes due to his narcolepsy. She expected staff to monitor and provide supervision of R3 while smoking.

The facility's smoking policy, dated 1/2012, identified residents would be assessed for safe smoking habits, would smoke in designated areas only, and would store smoking materials and lighters in designated area. The purpose of the policy was identified to provide a safe living environment, to reduce risk of fire, and to ensure

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F 323	Continued From page 24	F 323		

individuals' rights to clean air. The policy identified the following procedure:

1. During the preadmission process, potential residents will be informed of the facility smoking policy.

2. Residents who seek admission must agree to the smoking policy and verify their agreement in writing. [3-7. Omitted not pertinent to findings.]

8. Residents who have been assessed by the interdisciplinary team as incapable of smoking independently will only be allowed to smoke if staff/family/friends provide supervision. [9. Omitted not pertinent to findings.]

10. If resident demonstrates unsafe smoking, such as, smoking in non-designated areas, lighting smoking materials before leaving the building, burn holes on clothing, failure to store smoking materials as indicated, a resident incident report will be completed. Nursing will review with resident and/or responsible party to determine the plan of care.

11. With review of incident reports; if resident shows a pattern of unsafe smoking as noted in the policy the plan of care will be reviewed and possible discharge will be discussed.

12. Resident will be re-evaluated every three (3) months for safety or when a change is noted that might affect their ability to smoke safely and independently.

The immediate jeopardy that began on 4/19/14 was removed on 10/30/14, after the facility had initiated an IJ removal plan which included:

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F 323	Continued From page 25 providing one on one staff supervision for R3 while smoking; reassessment of R3's smoking risk factors; the provision of a fire proof apron when smoking; revision of the care plan for R3 to include the newly implemented interventions; education for all staff related to the newly developed interventions to ensure implementation; ongoing audits to ensure interventions were implemented; interviews of direct care staff and licensed nurses to determine whether they were aware of their responsibilities to monitor, provide the fire proof apron and documentation requirements when resident smokes, and to ensure all staff were aware of the safety plan for R3. Although the IJ was removed, noncompliance remained at the lower scope and severity level of a D, no actual harm with a potential for no more than minimal harm, isolated because a comprehensive assessment related to R3's physical safety had not been thoroughly completed.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure medications were administered for residents with less than a 5 % error rate, for 2 of 28 medication doses observed, affecting one resident (R23). The medication error rate was 7%.	F 332	F332 1. Residents have been monitored for an adverse effect and there has been non. 2. All residents that require specific dosing of liquid meds shall have medications administered based on current protocols. 3. All staff that administer medications shall be educated on the protocol for administration of liquid medications. Small syringes or adequately marked medication cups	

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F 332	Continued From page 26 Findings include: On 10/30/14, at 8:01 a.m. trained medication aide (TMA)-A was observed setting up R23's liquid medications for administration. The medications included: gabapentin (an anti-convulsant also used to enhance analgesia) solution 250 milligrams (mg) per 5 milliliters (ml), take 200 mg (4 ml) orally (po) three times a day (TID), and amantadine (Parkinson's medication) syrup 50 mg per 5 ml, take 50 mg (5 ml) po TID. TMA-A was observed to first pour the gabapentin solution into a 30 ml plastic medication cup and checked the measurement at eye level. It was noted upon reinspection by the surveyor, that the gabapentin solution was poured up to the 5 ml mark on the cup not the 4 ml as ordered. After the inaccurate measurement was noted, TMA-A confirmed there was an additional 1 ml of gabapentin poured than the physician's order. TMA-A further stated the medication cup did not have 1 ml increments to accurately obtain the ordered 4 ml dose so she would just fill it to 5 ml. TMA-A then searched the medication room, obtained a 10 ml syringe and withdrew 4 ml of the gabapentin solution from the medication cup with the use of the syringe. The TMA-A verified the medication remaining in the medication cup indicated she'd measured more than the prescribed 4 ml amount when using the cup vs the syringe. It was then observed that TMA-A measured R23's amantadine syrup into a 30 ml plastic medication cup at eye level. Upon re-inspection of the measured amantadine syrup at eye level, it was noted the liquid medication measured between the 2.5 ml and 5 ml mark on the medication cup. After the inaccurate dose of medication was noted by the surveyor, TMA-A confirmed the	F 332	shall be available for accurate measurements of the administered medications. 4. The DON or designee shall complete observational audits on all med passers by Dec 2, 2014 to assure compliance with the administration protocols as well as assuring. accurate med dosage administration. 5. Audit outcomes shall be reported to the QAA Committee for review & comment.	12-~~24~~ 8-14

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F 332	Continued From page 27 measurement was less than the prescribed 5 ml amount. TMA-A then measured 5 ml of the amantadine syrup with a 10 ml syringe to assure the accurate amount had been prepared for the resident. The undated Policy and Procedure for Liquid Medications included: "For liquid medications remove the cap from the bottle and place cap upside down on the work surface. Hold the medication cup at eye level and use your thumb to mark the desired level on the cup. Place the cup on a level surface and read the poured amount at eye level to check accuracy. Use a liquid syringe if unable to use a liquid measuring cup to get an accurate dosage."	F 332		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal	F 334	F334 1. R27 has been offered the pneumococcal vaccine which she has refused documentation has been completed to reflect her refusal per Facility protocol. 2. All resident records have been reviewed for compliance and/or outcomes of vaccinations completed per Facility protocol. 3. All staff have been educated on the Facility protocol for vaccinations. 4. The DON or designee shall audit all new admissions to assure compliance with the documentation standards of the Facility for vaccine compliance which includes refusals	

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F 334	Continued From page 28 representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or	F 334	with risk/benefit of the resident's decision. 5. All audit outcomes will be presented to the QAA Committee for review & comment.	12-~~24~~ 8-14

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F 334	Continued From page 29 the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their policy to ensure pneumococcal vaccinations were offered for 1 of 5 residents (R27) reviewed for immunizations. Findings include: The medical record for R27 lacked evidence that a pneumococcal vaccination had been offered or received following the resident's admission 3/28/14. When interviewed on 10/30/14, at 11:19 a.m. the director of nursing/infection control officer (DON/ICO) verified R27 had not been offered a pneumococcal immunization at the time of admission on 3/28/14. The DON stated the hospital would have offered this to the resident prior to the nursing home admission. However, the DON verified documentation in the medical record was lacking to indicate the immunization had been offered and/or received while in the hospital. Review of the facility's policy/procedure, Influenza and Pneumococcal Disease Prevention, revised 2/22/13, included: C. Resident should receive a pneumococcal vaccine unless they can recall prior vaccination or provide a record of immunization. 1) If 65 years of age or older, a one-time	F 334		

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F 334	Continued From page 30 revaccination is indicated if the resident was vaccinated more than 5 years previously and was under 65 years at the time of primary vaccination, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. D. Before offering the immunization, nursing facility personnel and each resident or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization. 1) Nursing facility personnel and the resident or the resident's legal representative have the opportunity to refuse immunization. E. The resident's medical record includes, but is not limited to: 1) Documentation that the resident or resident's legal representative was provided education regarding the benefits and potential side effects of the influenza and/or pneumococcal immunization. 2) Documentation that the resident either received the influenza and/or pneumoccal immunization or did not due to medical contraindications or refusal.	F 334		
F 497 SS=D	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents	F 497	F 497 1. E1 & E2 are no longer employed at the Facility. 2. All staff, actively employed for at least a year, will have an annual performance review filed in their personnel jacket. 3. All staff have had their personnel jacket audited for a performance review.	

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F 497	Continued From page 31 as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to conduct annual performance evaluations for 2 of 5 employees (E1 and E2) whose personnel records were reviewed. Findings include: Personnel files for 5 nursing assistants (NAs)who had been employed longer than 12 months, were requested from the administrator. During interview on 10/30/14, at 9:30 a.m. the administrator indicated he could not locate any performance reviews for 2 of the 5 NA files requested (E1 and E2). The administrator stated E1 and E2 were NAs who worked intermittently so annual performance evaluations had not been conducted. E1's personnel record lacked any evidence of an annual performance review since hire, 6/28/12. E2's personnel record lacked any evidence of an annual performance review since hire, 7/24/12. The administrator acknowledged during interview on 10/30/14 at 9:30 a.m., that both E1 and E2 were considered current employees.	F 497	4. The Administrator or designee shall be responsible to assure Department Heads complete annual reviews on a timely basis. 5. Audit outcomes shall be presented to the QAA Committee for review & comment.	12-~~24~~ 8-14

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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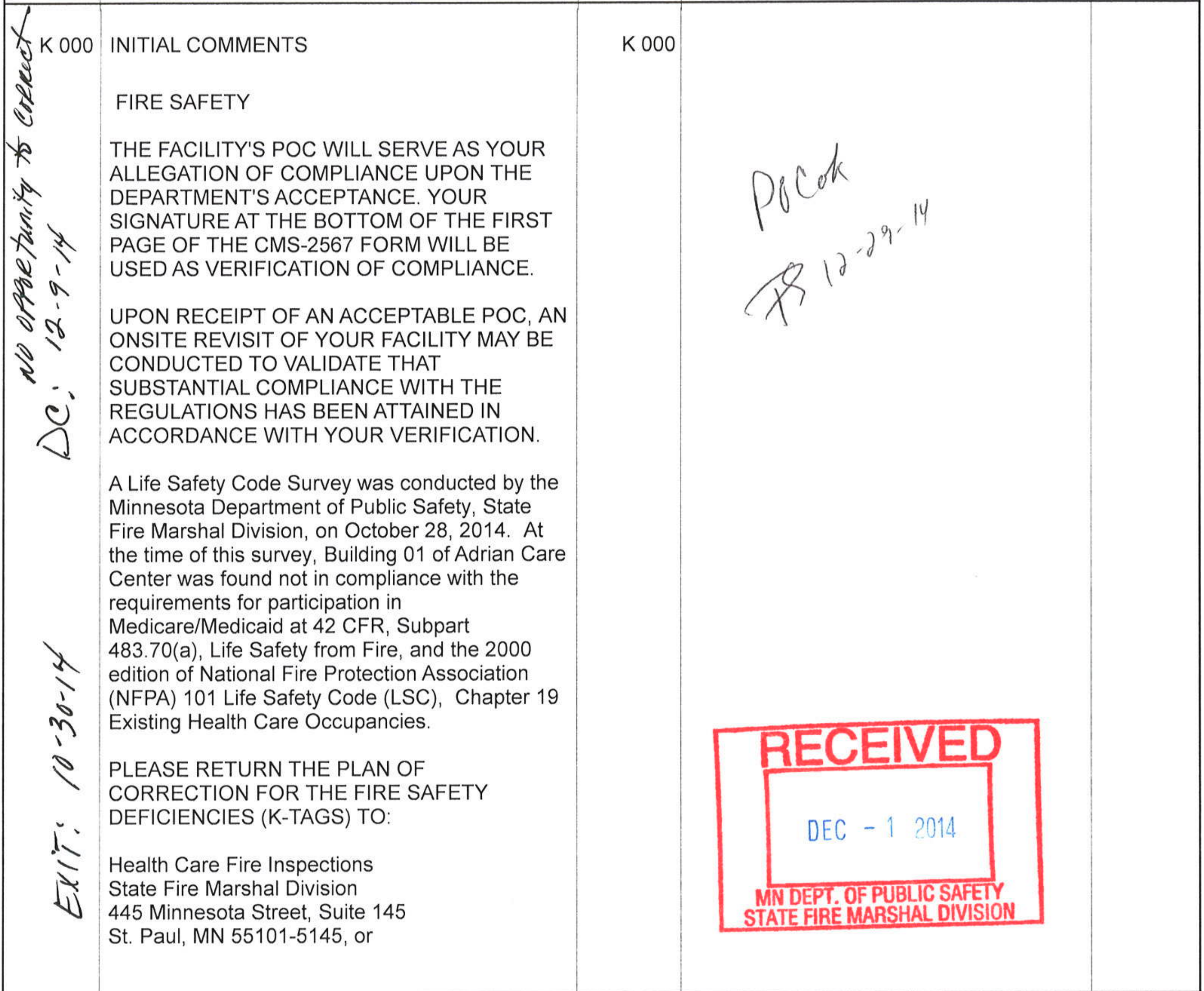
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADRIAN CARE CENTER	**603 LOUISIANA AVENUE** **ADRIAN, MN 56110**



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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on October 28, 2014. At the time of this survey, Building 01 of Adrian Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	POC ok 12-29-14 RECEIVED DEC - 1 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

No opportunity to correct
DC: 12-9-14
EXIT: 10-30-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dorothy Baker
TITLE: Administrator
(X6) DATE: 11-25-14

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245547	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**10/28/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADRIAN CARE CENTER	**603 LOUISIANA AVENUE** **ADRIAN, MN 56110**

(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
K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Adrian Care Center was constructed as follows: Building 01 - The original building was constructed in 1969, is one-story in height, has a partial basement, is fully fire sprinkler protected and is of Type II(000) construction; A building addition was constructed in 1976, it is one-story in height, has no basement, is fully fire sprinkler protected and is of Type II(000) construction. Building 02 - Consists of a link to an assisted living facility. It was built in 2009, is one-story in height, has no basement, is fully fire sprinkler protected and is of Type I(332) construction. There are no patient sleeping or treatment areas in Building 02. A two-hour fire wall separates the Nursing Home from an attached clinic, and the single communicating opening is protected by a labeled, self-closing, 90-minute fire-rated door assembly. Also, a two-hour fire wall with a labeled, self-closing, 90-minute fire-rated door assembly separates the 1969 building of Type II(000)	K 000		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245547	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADRIAN CARE CENTER	603 LOUISIANA AVENUE ADRIAN, MN 56110

(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
K 000	Continued From page 2 construction from the 2009 addition of Type I(332) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 30 beds and had a census of 26 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain a hazardous area door in accordance with NFPA 101 (00), Chapter 19, Section 19.3.2.1 and 19.3.6.3.2, and Chapter 8, Section 8.2.3.2.3.2. In a fire emergency, this deficient practice could adversely affect 12 of 30 residents, staff and visitors.	K 029	**K 029** The two kitchen doors that open to the corridors have been repaired with a positive door lock. This was completed November 3, 2014 by the Maintenance Supervisor. Maintenance Supervisor will monitor for proper closure.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245547	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADRIAN CARE CENTER	603 LOUISIANA AVENUE ADRIAN, MN 56110

(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
K 029	Continued From page 3 This finding was confirmed the maintenance director and administrator.	K 029		

Printed: 11/05/2014
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5547024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245547	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 2009 LINK TO ASSISTED LIVING B. WING	(X3) DATE SURVEY COMPLETED 10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADRIAN CARE CENTER	**603 LOUISIANA AVENUE ADRIAN, MN 56110**

(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
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on October 28, 2014. At the time of this survey, Building 01 of Adrian Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or By eMail to: Marian.Whitney@state.mn.us	K 000	POC ok PB 12-29-14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: See Bldg #1 for 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245547	A. BUILDING **01** B. WING ______	**10/28/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADRIAN CARE CENTER	**603 LOUISIANA AVENUE ADRIAN, MN 56110**

(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
K 000	Continued From page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Adrian Care Center was constructed as follows: Building 01 - The original building was constructed in 1969, is one-story in height, has a partial basement, is fully fire sprinkler protected and is of Type II(000) construction; A building addition was constructed in 1976, it is one-story in height, has no basement, is fully fire sprinkler protected and is of Type II(000) construction. Building 02 - Consists of a link to an assisted living facility. It was built in 2009, is one-story in height, has no basement, is fully fire sprinkler protected and is of Type I(332) construction. There are no patient sleeping or treatment areas in Building 02. A two-hour fire wall separates the Nursing Home from an attached clinic, and the single communicating opening is protected by a labeled, self-closing, 90-minute fire-rated door assembly. Also, a two-hour fire wall with a labeled, self-closing, 90-minute fire-rated door assembly separates the 1969 building of Type II(000) construction from the 2009 addition of Type I(332) construction.	K 000		

PRINTED: 11/17/2014
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245547	A. BUILDING **02 - 2009 LINK TO ASSISTED LIVING** B. WING ______	**10/28/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADRIAN CARE CENTER	**603 LOUISIANA AVENUE** **ADRIAN, MN 56110**

(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
K 000	Continued From page 2 construction from the 2009 addition of Type I(332) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 30 beds and had a census of 26 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain a hazardous area door in accordance with NFPA 101 (00), Chapter 19, Section 19.3.2.1 and 19.3.6.3.2, and Chapter 8, Section 8.2.3.2.3.2. In a fire emergency, this deficient practice could adversely affect 12 of 30 residents, staff and visitors. FINDINGS INCLUDE: On 10/28/2014 at 10:00 am, observation revealed that the two kitchen doors that open to the corridors did not positively latch when closed.	K 029	**K 029** The two kitchen doors that open to the corridors have been repaired with a positive door lock. This was completed November 3, 2014 by the Maintenance Supervisor. Maintenance Supervisor will monitor for proper closure. 	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245547	A. BUILDING **02 - 2009 LINK TO ASSISTED LIVING** B. WING	**10/28/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADRIAN CARE CENTER	**603 LOUISIANA AVENUE** **ADRIAN, MN 56110**

(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
K 029	Continued From page 3 This finding was confirmed the maintenance director and administrator.	K 029		