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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 3364

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00100

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245254**

2.STATE VENDOR OR MEDICAID NO.
(L2) **012198100**

3. NAME AND ADDRESS OF FACILITY
(L3) **REGINA SENIOR LIVING**
(L4) **1175 NININGER ROAD**
(L5) **HASTINGS, MN** (L6) **55033**

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) **01/01/2014**

6. DATE OF SURVEY **07/11/2016** (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)
06/30

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

12.Total Facility Beds **61** (L18)

13.Total Certified Beds **61** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	61			
(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 :
Susanne Reuss, Unit Supervisor 07/11/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 07/26/2016 (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
06/02/1982
(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.
00000
(L31)

30. REMARKS
Posted 07/29/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/05/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245254
July 26, 2016

Ms. Kari Everson, Administrator
Regina Senior Living
1175 Nininger Road
Hastings, MN 55033

Dear Ms. Everson:

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 July 1, 2016 the above facility is certified for or recommended for:

61 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 61 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 26, 2016

Ms. Kari Everson, Administrator
Regina Senior Living
1175 Nininger Road
Hastings, MN 55033

RE: Project Number S5254025

Dear Ms. Everson:

On June 7, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 25, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On July 11, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 25, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 1, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 25, 2016, effective July 1, 2016 and therefore remedies outlined in our letter to you dated June 7, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245254 Y1	A. Building B. Wing Y2	7/11/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0279	Correction	ID Prefix F0312	Correction	ID Prefix F0329	Correction
Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(l)	Completed
LSC	07/01/2016	LSC	07/01/2016	LSC	07/01/2016
ID Prefix F0334	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.25(n)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	07/01/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 07/26/2016	SIGNATURE OF SURVEYOR 16022	DATE 07/11/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
5/25/2016

☐ 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 — ID: 3364

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(L1) **245254**

2.STATE VENDOR OR MEDICAID NO.
(L2) **012198100**

3. NAME AND ADDRESS OF FACILITY
(L3) **REGINA SENIOR LIVING**
(L4) **1175 NININGER ROAD**
(L5) **HASTINGS, MN** (L6) **55033**

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) **01/01/2014**

6. DATE OF SURVEY **05/25/2016** (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)
06/30

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

12.Total Facility Beds **61** (L18)

13.Total Certified Beds **61** (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
	61			
(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 :
Sheryl Reed, HFE NE II — 06/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 06/30/2016 (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 :
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22. ORIGINAL DATE OF PARTICIPATION
06/02/1982
(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.
00000
(L31)

30. REMARKS
Posted 07/05/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 7, 2016

Ms. Kari Everson, Administrator
Regina Senior Living
1175 Nininger Road
Hastings, MN 55033

RE: Project Number S5254025

Dear Ms. Everson:

On May 25, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 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.

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:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
susanne.reuss@state.mn.us
Telephone: (651) 201-3793 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 4, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 Post Certification Revisit (PCR) 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 remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 August 25, 2016 (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 November 25, 2016 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

(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 An onsite Sunday start survey was conducted by surveyors of this department on May 22, 23, 24 and May 25, 2016 to determine compliance with federal regulation. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=E	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	F 279		7/1/16

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

Electronically Signed | 06/17/2016

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
	245254	A. BUILDING _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

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F 279	Continued From page 1 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). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop comprehensive individualized care plans to include target behaviors, mood symptoms and side effect monitoring, and/or effectiveness of scheduled and as needed medications for 4 of 5 residents (R78, R5, R9, R26) in the sample reviewed for unnecessary medications. Findings include: R78, admitted to he facility on 4/11/16. The only care plan avaiable to review was an initial care plan, dated 4/12/16. The care plan did not include side effect monitoring and/or include non-pharmalogical interventions for depression and insomnia. In addition the plan did not identify side effect monitoring for use of anticoagulants, diuretics and insulin. A review of the physician order sheets, dated May 2016, indicated R72 received warfarin (a blood thinner), Metolazone (a diuretic) scheduled and as needed, insulin scheduled and as needed, Trazadone for sleep and Lexapro for depression. The initial care plan was developed at time of admission, however lacked identifying problems such as depression, insomnia, diabetes or congestive heart failure that included the use of a diuretic and a blood thinner medication. The initial	F 279	1. Responses to individual residents: a. R78: Nursing staff educated on import ace of following MD order. Order was obtained for clarification to notify nurse of wt. gain > 3lbs. in a day or >5lbs. in one week. NAR sheet and care plan to include weighing resident every day in w/c for accuracy. b. R72: Revised temporary care plan to include above concerns. Staff education to be provided to new care plan template per facility policy and accuracy of information by July 1, 2017. c. R5: Care plan will be updated to identify diagnosis of insomnia and receives medication for sleep. d. R9: Care plan updated to identify Seroquel as an antipsychotic medication and interventions for monitoring for side effects. Target behaviors will be added. e. R26: Care plan will be updated for interventions to monitor side effects, non-pharmacological interventions, and sleep medication interventions. Sleep monitoring added to treatment sheet. 2. Follow Up / Practice Changes: a. Health unit Coordinator to ensure ICD 10 diagnosis for each medication entered. Missing ICD 10 audits to be completed weekly x 4 weeks. b. Care plans/ updates/ MDS schedules	

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F 279	Continued From page 2 care plan lacked any direction for monitoring of any side effects of medications or monitoring of amount of hours sleep. The care plan lacked identification of signs/symptoms of depression and insomnia and did not identify nonpharmacological interventions to direct R78's care. On 5/24/17 at 10:26 a.m. R78 reported having difficulty sleeping at night recently and had asked for some medication. Staff reported she had already had the medication to help with sleep. When asked if the nursing staff offered anything else, like a warm blanket or a snack, R78 stated, "No they did not. And its really bad when you can't sleep. I was wiped the next day". R78 did not think she was taking an antidepressant, but was aware of the other medications. The care plan identified R78 was on a cardiac diet, was having blood glucose monitoring four time a day,was using oxygen at 2-3 liters/min and had INR (International Normalized Ratio for blood clotting time). The care plan was not developed for the use of Trazadone for sleep, for Lexapro an antidepressant, or for the side affects of use of a blood thinner such as excessive bruising or bleeding. The care plan identified the use of oxygen and daily weights but did not identify interventions if the use of an as needed additional medication diuretic was needed or updating the nurse practioner every week with weights. On 5/24/16 at 1:51 p.m., licensed practical nurse (LPN)-A reviewed the electronic medication and treatment sheets and was unable to locate any monitoring of sleep. R78 had not had any indication for use of the as needed diuretic and was receiving prn doses of insulin per her sliding	F 279	to be discussed at IDT weekly. Any new psychotropic/ anticoagulant, insulin, or diuretic medications for week prior to be discussed, and added to care plan, including target behaviors which includes non-pharma logical interventions, side effect, and sleep monitoring. To be monitored quarterly in accordance with MDS schedule. c. Health Unit Coordinator to add target behavior monitoring and/or side effect monitoring to treatments in Matrix upon each admission for residents currently taking psychotropic medications, diuretics, and anti-coagulants. These Items have been added to admission checklist. d. Health Unit Coordinator to add target behavior monitoring and/or side effect monitoring to treatments in Matrix upon each admission for residents currently taking psychotropic medications, diuretics, and anti-coagulants. These Items have been added to admission checklist. 3. On-Going Monitoring: a. Care plans/ updates/ MDS schedules to be discussed at IDT weekly. Any new psychotropic/ anticoagulant, insulin, or diuretic medications for week prior to be discussed, and added to care plan, including target behaviors which includes non-pharma logical interventions, side effect, and sleep monitoring. To be monitored quarterly in accordance with MDS schedule. b. Quality council will review information gathered from IDTeam meetings and determine course of action for monitoring/review by quality council. 4. Will be in substantial compliance for	

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F 279	Continued From page 3 scale on a consistent basis. LPN -A verified there was no monitoring of side effects of either anti depressant, or target behavior identified for the use of Lexapro or monitoring of sleep for the Trazodone. On 5/24/16 at 10:58 a.m., the registered nurse clinical manager (RN)-A indicated the initial care plan was the only care plan available at this time. RN-A explained R78 was supposed to discharge but never did and a full care plan was never developed and said a complete care plan should have been developed after the twenty first day. On 5/24/16 at 2:05 p.m., the minimum data set nurse, a consultant, verified R78 did not have a developed comprehensive care plan and added R78's plan was to discharge before one was needed. RN-C added one will be completed as soon as possible. On 5/25/16 at 2:30 p.m. the director of nursing verified R78 wanted to discharge home with assistance but never did. It was her expectation a full care plan should have been developed including all potential problems and individualized approaches to direct care for the resident. Policy and Procedure Statement regarding care plans, last revised August 2016 indicated the facility would provide a temporary care plan within 24 hours of admission and a complete and comprehensive care plan by the resident's 21st day of admission. Procedure: Bullet1 reads: The registered nurse will initial the admission care plan form within 24 hours of admission. Bullet 3: The team will continue to collect additional information and data over the next 14 days and will develop a comprehensive care plan	F 279	F279 by July 1, 2016.	

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F 279	Continued From page 4 that contains both strengths and dependencies. The facility did not develop a comprehensive plan of care for insomnia for R5. R5's face sheet with admit date 5/19/2008, R5 had diagnoses that included insomnia. R5's physician order report dated 4/25/16 - 5/25/16, indicated R5 had an order for Trazodone 50 mg 1 tablet by mouth at bedtime, and trazadone 50 mg prn, may give if scheduled dose ineffective. R5's care plan did not identify R5 had a diagnoses of insomnia and received medication for sleep. Interview with the director of nursing (DON) on 5/25/16 at 1:30 p.m., verified R5 was medicated daily for sleep and it should have been noted on the plan of care. R9 was not monitored for changes in orthostatic blood pressure, target behaviors and medication effectiveness due to antipsychotic/antidepressant medication use. R9's face sheet with admit date 3/23/16, R9 had diagnoses that included Nocturnal psychosis, Insomnia and depression. Furthermore, R9's Physician Orders dated 3/23/16, indicated R9 had an order for Seroquel 12.5 mg 1 tablet by mouth at bedtime. Celexa 20 mg 1 tab by mouth daily. R9's care plan dated 4/17/16, revealed, "PROBLEM: At risk for adverse health events related to concurrent use of both antipsychotic and antidepressant medications for long standing diagnoses of Major Depressive Disorder, and Nocturnal psychosis." The care plan did not	F 279		

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identify Seroquel as an antipsychotic medication and lacked direction for staff to monitor for side effects, orthostatic blood pressure and target behaviors.

On 5/24/16 at 11:31 a.m. registered nurse (RN)-A reviewed R9's medical record and verified medical record lacked resident target behavior monitoring, side effect and effectiveness of monitoring medications that includes antipsychotic and antidepressant medications and monthly orthostatic blood pressure.

On 5/25/16 at 1:59 p.m. the director of nursing verified staff were supposed to check monthly orthostatic blood pressures as a potential side effect of psychoactive medication use, document non-pharmacological interventions (includes target behavior) used for psychoactive medications, and/or document the effectiveness of medications used.

R26's care plan lacked antipsychotic and antidepressant medication side effect monitoring, non-phamarcological interventions and lacked staff direction for sleep medication interventions.

R26's face sheet indicated R26 was admitted to the facility on 3/31/16, with diagnoses of paranoid personality disorder and insomnia.

The physician order report dated 4/25/16 - 5/25/16, indicated R26 had an order for Olanzapine 10 milligrams (mg) twice a day and Trazadone 50 mg at bedtime.

The care plan dated 4/8/16, revealed "problem: resident at risk for adverse health events related

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F 279	Continued From page 6 to use of antipsychotic and antidepressant medications for diagnosis of Paranoid Personality Disorder, Insomnia. Resident tolerating medication regimen effectively and without report of adverse side effects. The goal was R26 will remain free from adverse effects of psychotropic medications." The care plan lacked direction for staff to monitor adverse side effects, non-pharmacological interventions and sleep medication interventions. On 5/25/16, at 10:24 a.m. registered nurse (RN)-A stated nurses will write progress notes when they observe side effects of medications. On 5/25/16, at 10:31 a.m. RN-A stated staff should be monitoring sleep with use of Trazadone. On 5/25/16, at 2:39 p.m. director of nursing (DON) stated she started medication side effect monitoring sheets for nursing to complete. She started treatment sheets the beginning of May for behaviors, non-pharmacological interventions, and effectiveness. Side effects were listed also for psychotic medications and antidepressants and she would be adding sleep monitoring. DON stated she had not completed R26 and did not yet have sleep monitoring done for R26. DON further stated R26 should have a sleep monitoring sheet completed to monitor hours awake every shift and whether R26 was sleeping during the day. DON stated she expected sleep monitoring should be done.	F 279		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of	F 312		7/1/16

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F 312	Continued From page 7 daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to assure 1 of 1 resident (32), dependent on staff for personal cares, was provided additional bathing and/or shampoo. Findings include: R32's quarterly minimum data set (MDS), dated 3/31/16, identified R32 as being cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status) and needed extensive assist of one staff person for personal grooming including hair washing and bathing. On 5/22/16 at 5:10 p.m. R32 was observed to be sitting in a lounge chair in her room with the window coverings closed. During interview R32 reported she had asked staff to wash her hair more often, explaining that it gets oily, and said that it hadn't been shampooed any more often for some time. When visited on 5/25/16 at approximately 10:15 a.m. R32 was sitting in the lounge chair in her room. R32's shoulder length hair was observed to be somewhat stringy and shiny. When R32 was asked if staff gave her a shampoo cap the previous night, R32 reported, "no" and added, "it doesn't make you feel very good". A review of the LTC (long term community) nursing assistant work sheet directed staff R32	F 312	1. Responses to individual residents: a. F32: Resident Bath Aide to offer bath to resident 2x weekly, along with washing resident's hair with shampoo cap 2 x weekly on days when bath aide available during the week. Bath aide to chart on refusal of baths twice weekly, and on refusal of hair shampoo in matrix. b. Updated Information added to Aide sheet, and care plan c. Bath aide to be educated on how to chart refusal appropriately 2. Follow Up / Practice Changes a. Will review ADL's and assistance needed for dependent residents quarterly with the MDS reviews. Will discuss in IDTeam. 3. On-Going Monitoring: Will audit use of shampoo cap by interviewing resident each week x 4 weeks to ensure this is happening. Will also interview the resident during the quarterly MDS process to ensure she is still having her shampoo cap completed. 4. Will be in substantial compliance for F312 by July 1, 2016.	

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F 312	Continued From page 8 was to get a bath twice a week and have hair washed with a shampoo cap every Sunday and Tuesday. On 5/24/16 at 11:00 a.m., when asked about the bathing and shampoo schedule for R32, registered nurse (RN)-A indicated the bath aide would be the one to talk to regarding how often R32 received a bath. Bath/skin check off forms were provided for the once a week bath, but there was no documentation of a second bath or shampoo cap being offered. On 5/24/16 at approximately 11:20 a.m. the nursing assistant (NA)-A reported R32 takes a weekly bath but refuses the second bath. NA-A added the shampoo cap should be completed on evenings. On 5/25/16 at 10:30 a.m. the director of nursing (DON) was interviewed regarding a 2nd bath and use of shampoo cap for R32. The DON reported knowing the shampoo caps had been provided to R32 for years and was unaware they were not being offered.	F 312		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329		7/1/16

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F 329	Continued From page 9 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to adequately assess and monitor clinical indictors and develop non-pharmalogical interventions for the continued use of psychoactive medications for 4 of 5 residents (R78, R9, R26, R5) who were reviewed for unnecessary medications. Findings include: R78 was not monitored for target mood/behaviors and medication effectiveness due to the use of antidepressant medication. R78 also did not have a comprehensive care plan developed that identified target behaviors, accurate monitoring of depression and insomnia or included non-pharmalogical interventions for depression or insomnia, and did not identify side effect monitoring for use of anticoagulants, diuretics and insulin. R78, admitted on 4/11/16, had an initial care plan in place to direct staff on how to care for the	F 329	1. Responses to individual residents: a. R78: Target behavior / mood monitoring and medication effectiveness monitoring will be put into place.Comprehensive care plan will identify target behaviors and accurate monitoring of depression and insomnia.Comprehensive care plan will reflect non-pharmalogical interventions for depression and anxiety.Comprehensive care plan will reflect side effect monitoring for anticoagulants, diuretics, and insulin. b. R9: monitoring will be put into place to monitor for target behaviors, medication effectiveness, and side effect monitoring forantipsychotic/antidepressant medication use.Comprehensive care plan will reflect Seroquel as an antipsychotic medication and will include direction to staff for monitoring side effects and target behaviors.	

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F 329	Continued From page 10 resident. On 5/24/17 at 10:26 a.m. R78 reported she had difficulty sleeping at night recently and had asked for some medication. Staff reported she had already had the medication to help with sleep. When asked if the nursing staff offered anything else, like a warm blanket or a snack, R78 stated, "No they did not. And its really bad when you can't sleep. I was wiped the next day". R78 did not think she was taking an antidepressant, but was aware of the other medications. R78 added she thought her feet were slightly edematous. The admission minimum data set, dated 4/18/16, indicated R78 was cognitively intact, and was identified to have diagnoses that included congestive heart failure, chronic obstructive disease, diabetes, depression and insomnia. R78 was admitted 4/11/16 with physician orders that included an order for Lexapro,(an anti-depressant) 10 mg every morning, trazodone (an antidepressant used for insomnia) 50 mg at bedtime, Coumadin (a blood thinning agent) 5 mg once a day on Sunday, Tuesday, Wednesday, Friday and Saturday, and 7.5 mg once a day on Monday, and Thursday., Lantus (insulin)with scheduled doses of 15 units subcutaneous at hours sleep and 35 units before breakfast, Novolog (insulin aspart) subcutaneous three times a day 4 units and a sliding scale of Novolog three times a day. R78 was on scheduled dose of Metolazone (diuretic) 2.5 mg on Monday and Saturday, and had Metolazone 2.5 mg as needed for weight gain over 3 pounds a day. A review of the April/May medication administration record (MAR) showed R78 received the medication daily, received the as needed sliding scale of	F 329	c. R26: Side effect, symptom, and sleep monitors will be added for staff to complete. d. Comprehensive care plan will include direction for monitoring adverse side effects of antipsychotic/antidepressant medications. e. Sleep monitoring will be conducted. 2. Follow Up/Practice Changes: a. All residents to have fall risk assessment upon admission, and quarterly with MDS schedule. Fall risk observation includes orthostatic blood pressure, and includes dizziness related to antipsychotic and other medications. If resident is unable to stand, staff must obtain a lay to sit blood pressure. b. 2. Licensed staff to be educated on fall risk assessment and completion in entirety by July 1, 2016. c. Aims assessment to be completed at admission, and quarterly to monitor side effects of psychotropic medications d. Health Unit Coordinator to add target behavior monitoring and/or side effect monitoring to treatments in Matrix upon each admission for residents currently taking psychotropic medications, diuretics, and anti-coagulants. These Items have been added to admission checklist. e. 5. Care plans/ updates/ MDS schedules to be discussed at IDT weekly. Any new psychotropic/ anticoagulant, insulin, or diuretic medications for week prior to be discussed, and added to care plan, including target behaviors which includes non-pharma logical interventions, side effect, and sleep monitoring. To be monitored quarterly in accordance with	

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F 329	Continued From page 11 insulin regularly, and had not used the as needed metolazone for increase weight. Laboratory testing was being conducted on a regular bases for identifying the INR (International Normalized Ratio for blood clotting time). The next schedule lab test was for 5/26/16. A review of the MAR contained no documentation of mood/behavior or sleep monitoring nor any non-pharmacological interventions related to the use of the antidepressants and medication used for insomnia. R78's current care plan, dated 4/11/16, was the initial temporary care plan developed upon admission. An individualized comprehensive care plan for R78 had never been developed after R78 remained at the care facility for over twenty-one days. The initial care plan did not identify the use of the psychotropic mediations for depression or sleep or identify target behaviors or non-pharmacological interventions related to the use of these medications. The current care plan did not identify the problem of the use of an anticoagulant or the side effect monitoring for the use of an anticoagulant such as excessive bruising or bleeding and did not identify the use of a diuretic or interventions as the perimeters of weight gain and what interventions should be taken. On 5/24/16 at 1:51 p.m., licensed practical nurse (LPN)-A reviewed the electronic medication and treatment sheets and was unable to locate any monitoring of sleep. R78 had not had any indication for use of the as needed diuretic and had received as needed doses of insulin per the sliding scale on a consistent basis. LPN -A verified there was no monitoring of side effects of	F 329	MDS schedule. f. Update to standing house orders to remove institute 3 day sleep record by nursing staff if the patient is complaining of sleeping difficulty. 3. On-Going Monitoring: a. a. Care plans/ updates/ MDS schedules to be discussed at IDT weekly. Any new psychotropic/ anticoagulant, insulin, or diuretic medications for week prior to be discussed, and added to care plan, including target behaviors which includes non-pharma logical interventions, side effect, and sleep monitoring. To be monitored quarterly in accordance with MDS schedule. b. Quality council will review information gathered from IDTeam meetings and determine course of action for monitoring/review by quality council. 4. Will be in substantial compliance for F279 by July 1, 2016.	

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either anti depressant, or target behavior identified for the use of Lexapro or monitoring of sleep for the Trazodone.

On 5/24/16 at 10:58 the registered nurse clinical manager (RN)-A indicated the initial care plan was the only care plan available at this time. RN-A explained the patient was always going to discharge but never did. Therefore a full accurate care plan was never developed. RN-A verified a complete care plan should have been developed after the twenty first day.

On 5/24/16 at 2:05 the minimum data set nurse, a consultant, verified R78 did not have a comprehensive care plan and added R78's plan was to discharge before one was needed. RN-C added one will be completed as soon as possible.

On 5/25/16 at 2:30 p.m. the director of nursing verified R78 wanted to discharge home with assistance but never did. It was the DON's expectation a full care plan should have been developed including all potential problems and individualized approaches to direct care for the resident.

A review of the Restraints/Chemicals Psychotropic Medications policy, dated 12/2002, identified the Classification of drugs referred to in this policy include antipsychotics, sedatives, including short and long acting benzodiazapines and hypnotics. It further reads: Procedure 7. Documentation to support the continued use of psychotropic drugs includes, but is not limited to: a. A physician note indicating that the use of the drug or continued use is clinically appropriate and the reasons why this use is clinically appropriate. b. Physician, nursing or other health professional

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	245254	A. BUILDING _____ B. WING _____	05/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

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documentation indicating that the resident is being monitored for adverse consequences or complications of drug therapy.

Under the heading Antipsychotics: Bullet 5. reads: Nonpharmacologic behavior modification activities and their effects as well as the effect of pharmacologic behavioral modifiers are addressed in nursing notes in the resident's chart and in the resident care planning. The physician in the process of assessing the resident's response to therapy reviews these records.

R9 was not monitored for changes in orthostatic blood pressure, target behaviors and medication effectiveness due to antipsychotic/antidepressant medication use.

R9's face sheet with admit date 3/23/16, R9 had diagnoses that included Nocturnal psychosis, Insomnia and depression. Furthermore, R9's Physician Orders dated 3/23/16, indicated R9 had an order for Seroquel 12.5 mg 1 tablet by mouth at bedtime. Celexa 20 mg 1 tab by mouth daily.

On 5/24/16 at 8:15 a.m. R9 was observed to be awake, sitting up in a wheelchair next to the sink combing her hair. When approached and interviewed regarding the medications, Seroquel and Celexa, that she takes, R9 stated she did not notice or experience any side effects from the medications but did identify that she likes to comb her hair independently. During the interview R9 was observed to be relaxed with no behaviors noted.

R9's Minimum Data Set (MDS) dated 3/30/16, indicated R9 had an antipsychotic medication (Seroquel) and antidepressant (Celexa) X 7 days

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F 329	Continued From page 14 within the last 7 days Assessment Reference Date (ARD) period. R9 admission CAAs (care area assessment) dated 4/5/16 reads. "CAA triggered due to resident receiving both antidepressant and antipsychotic medications. Long-standing depression, nocturnal psychosis. Resident tolerating medication regimen effectively, no side effects noted. Goal of care planning is to avoid adverse health events related to use of psychotropic medications. Referral to Consulting Pharmacist for drug regimen review per facility. No other outside referrals needed at this time. Proceed to care plan." R9's care plan dated 4/17/16, revealed, "PROBLEM: At risk for adverse health events related to concurrent use of both antipsychotic and antidepressant medications for long standing diagnoses of Major Depressive Disorder, and Nocturnal psychosis." The care plan did not identify Seroquel as an antipsychotic medication and lacked direction for staff to monitor for side effects, orthostatic blood pressure and target behaviors. The MAR (Medication Administration Record) for March 2016, April 2016 and May 2016, indicated R9 received Seroquel 12.5 mg by mouth. On 5/24/16 at 11:31 a.m. registered nurse (RN)-A reviewed R9's medical record and verified medical record lacked resident target behavior monitoring, side effect and effectiveness of monitoring medications that includes antipsychotic and antidepressant medications and monthly orthostatic blood pressure.	F 329		

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F 329	Continued From page 15 On 5/25/16 at 1:59 p.m. the director of nursing verified staff were supposed to check monthly orthostatic blood pressures as a potential side effect of psychoactive medication use, document non-pharmacological interventions (includes target behavior) used for psychoactive medications, and/or document the effectiveness of medications used. Policy and procedure title PSYCHOTROPIC MEDICATION USE ANTICIPATED FULL IMPLEMENTATION BY JUNE 2016 dated May 2016, reads, "Non pharmacological interventions will be implemented and documented in Treatment record for all residents on PRN [as needed] psychoactive medications." R26 did not receive medication side effect monitoring with the use of Olanzapine (an antipsychotic) used for paranoia, nor adequate sleep monitoring with the use of Trazadone (an antidepressant) for insomnia. R26's face sheet indicated R26 was admitted to the facility on 3/31/16, with diagnoses of paranoid personality disorder and insomnia. On 5/25/16, at 10:10 a.m. R26 was observed seated in wheelchair in dining room facing the window. R26 was sleeping with no behaviors noted at that time. R26's resident mood interviews (PHQ-9) dated 4/5/16, at 11:31 a.m. and dated 5/25/16, at 10:27 a.m. indicated R26 did not have trouble falling, staying asleep or sleeping too much. The physician order report dated 4/25/16 - 5/25/16, indicated R26 had an order for	F 329		

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Olanzapine 10 milligrams (mg) twice a day and Trazadone 50 mg at bedtime. The orders lacked side effect and symptom monitoring and sleep monitoring.

Review of the Medication Administration Record (MAR) dated 5/1/2016-5/25/2016, revealed R26 received olanzapine two times a day and received trazadone at hour of sleep. The MAR lacked side effect and symptom monitoring and sleep monitoring.

The Care area assessment (CAA) dated 4/7/16, indicated R26 received antipsychotic medication. R26 was at risk for falls. Admission Minimum Data Set (MDS) dated 4/7/16, indicated R26 required extensive two person assist with transfers.

The care plan dated 4/8/16, indicated R26 at risk for adverse health events related to use of antipsychotic and antidepressant medications and was tolerating medication without report of adverse side effects. The goal was to remain free from adverse effects of medications. The care plan lacked direction for staff to monitor for adverse side effects.

On 5/25/16, at 10:24 a.m. registered nurse (RN)-A stated nurses will write progress notes when they observe side effects of medications.

On 5/25/16, at 10:31 a.m. RN-A stated staff should be monitoring sleep with use of Trazadone.

On 5/25/16, at 11:29 a.m. when asked about medication side effect monitoring, consultant pharmacist (CP) stated nurses should look for

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change of condition, monitor, and write a progress note. CP stated he had noted R26 had no concerns with sleep. R26 also had paranoia and CP indicated he did expect sleep monitoring to be done.

On 5/25/16, at 2:39 p.m. director of nursing (DON) stated she started medication side effect monitoring sheets for nursing to complete. She started treatment sheets the beginning of May for behaviors, non-pharmacological interventions, and effectiveness. Side effects were listed also for psychotic medications and antidepressants and she would be adding sleep monitoring. DON stated she had not completed R26 and did not yet have sleep monitoring done for R26. DON further stated R26 should have a sleep monitoring sheet completed to monitor hours awake every shift and whether R26 was sleeping during the day. DON stated she expected sleep monitoring should be done.

The undated facility standing house orders indicated "institute 3 day sleep record by nursing staff if the patient is complaining of sleeping difficulty."

R5's face sheet with admit date 5/19/2008, R5 had diagnoses that included insomnia. R5's physician order report dated 4/25/16 - 5/25/16, indicated R5 had an order for Trazodone 50 mg 1 tablet by mouth at bedtime, and trazadone 50 mg prn, may give if scheduled dose ineffective.

Review of R5's electronic medication administration record (EMAR) for May 2016, indicated on 5/11/16 R5 received the prn dose of Trazadone. There was a 0 in the row listed as

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F 329	Continued From page 18 Non-Pharmacological. Review of R5's EMAR for 2/2016 indicated on 2/28/16 E5 received the prn dose of Trazadone, and the Non-Pharmacological row had nothing in it. Interview with the Director of Nursing on 5/25/16 at 1:30 p.m., she indicated the expectation is for non-pharmacological interventions to be tried first, and the the prn to be administered. She verified the dates in February and May when the prn was given, no nonpharmacological intervention were attempted. Review of R5's record included a form labeled sleep monitoring. Review of the forms dated for March, April, and May 2016, indicated R5 was awake on the evening shift, and no other shift had completed the form. Interview with the DON on 5/25/16 at 1:30 p.m., she verified the forms were incomplete, and R5's sleep patterns could not be determined from the incomplete forms. She indicated a new form was started the beginning of May 2016, and R5 must have been missed.	F 329		
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	F 334		7/1/16

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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 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

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F 334	Continued From page 20 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 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 ensure each resident received an influenza immunization or had documented evidence of the vaccination being contraindicated for 2 of 5 residents (R1 and R9) in the sample reviewed for immunizations. Findings include: Review of R1's medical record lacked documentation if an influenza vaccination had been received, was contraindicated or refused. Review of R9's medical record lacked documentation if an influenza vaccination had been received, was contraindicated or refused. On 5/25/16, at 12:53 p.m. registered nurse (RN)-A/clinical manager stated she expected the influenza and pneumococcal immunization record to be completed at admission. The information was included with the resident admission packet. On 5/25/16, at 1:13 p.m. RN-B/quality management coordinator stated her expectation	F 334	1. Responses to individual residents: None 2. Follow Up / Practice Changes a. Will review and revise Influenza and Pneumococcal immunization policy(ies). b. The medical record will include education of the influenza immunization, recept of immunization or declination. 3. On-Going Monitoring: Will add vaccination audits to the quality council agenda. Quality council will review vaccinations to ensure continued compliance. 4. Will be in substantial compliance for F312 by July 1, 2016.	

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F 334	Continued From page 21 was the immunizations were offered, or if given previously, they should have record of when given. The undated facility standing house orders indicated "per CDC guidelines may administer influenza vaccine to patients who have not already received it unless contraindicated (i.e., temp > 100o F, allergy to eggs or influenza vaccine." Facility Influenza, Prevention and Control of Seasonal policy dated revised August 2014 indicated "Vaccination 2. Unless contraindicated, all residents and staff will be offered the vaccine."	F 334		

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

F5254024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING **01 - NURSING HOME** B. WING _____	**05/24/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS	K 000		

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Regina Senior Living was found not in substantial 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

This facility will be surveyed as two separate buildings. Regina Senior Living is a 1-story building, with a full basement. The facility was built in 1965 and was determined to be of Type II(111) construction.

This facility will be surveyed as two separate buildings. The facility is fully sprinklered, with heads in the closets of all resident sleeping rooms. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridor and resident sleep rooms that is monitored for automatic fire department notification.

The facility has a capacity of 61 beds and had a census of 51 beds at the time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is MET

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	245254	A. BUILDING **02 - 2012 ADDITION BLDG** B. WING _____	**05/24/2016**

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