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: 3AGG
Facility ID: 00754

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245509**

2. STATE VENDOR OR MEDICAID NO. (L2) **015540300**

3. NAME AND ADDRESS OF FACILITY
(L3) **ADAMS HEALTH CARE CENTER**
(L4) **810 WEST MAIN STREET**
(L5) **ADAMS, MN** (L6) **55909**

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)

6. DATE OF SURVEY **8/9/2016** (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) **09/30**

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
X 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
	49			
(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 :
Wendy Buckholz, HFE NE II 8/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 8/12/2016 (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 :

22. ORIGINAL DATE OF PARTICIPATION **01/01/1988** (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. **03001** (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 ALL MINNESOTANS

CMS Certification Number (CCN): 245509

August 12, 2016

Ms. Georgette Hinkle, Administrator
Adams Health Care Center
810 West Main Street
Adams, MN 55909

Dear Ms. Hinkle:

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 13, 2016 the above facility is certified for:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 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
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 12, 2016

Ms. Georgette Hinkle, Administrator
Adams Health Care Center
810 West Main Street
Adams, MN 55909

RE: Project Number S5509025

Dear Ms. Hinkle:

On July 5, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 16, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On August 9, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on July 20, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 16, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 13, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 16, 2016, effective July 13, 2016 and therefore remedies outlined in our letter to you dated July 5, 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,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
245509 Y1	Y2	8/9/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS HEALTH CARE CENTER	810 WEST MAIN STREET ADAMS, MN 55909

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 F0241 Reg. # 483.15(a) LSC	Correction Completed 07/13/2016	ID Prefix F0247 Reg. # 483.15(e)(2) LSC	Correction Completed 07/13/2016	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 07/13/2016
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 07/13/2016	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 07/13/2016	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 07/13/2016
ID Prefix F0315 Reg. # 483.25(d) LSC	Correction Completed 07/13/2016	ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 07/13/2016	ID Prefix F0428 Reg. # 483.60(c) LSC	Correction Completed 07/13/2016
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 (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	8/12/2016	31767	8/9/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**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
6/16/2016	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245509	A. Building 01 - MAIN BUILDING 01 B. Wing	7/20/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS HEALTH CARE CENTER	810 WEST MAIN STREET ADAMS, MN 55909

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 Reg. # NFPA 101 LSC K0025	Correction Completed 06/16/2016	ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 06/16/2016	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	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
STATE AGENCY ☐	TL/kfd	8/12/2016	37008	7/20/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/15/2016

☐ 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

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 3AGG
Facility ID: 00754

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245509**

2. STATE VENDOR OR MEDICAID NO. (L2) **015540300**

3. NAME AND ADDRESS OF FACILITY
(L3) **ADAMS HEALTH CARE CENTER**
(L4) **810 WEST MAIN STREET**
(L5) **ADAMS, MN** (L6) **55909**

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)

6. DATE OF SURVEY **06/16/2016** (L34)

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	

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (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
	49			
(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 :
Lisa Carey, HFE NE II 07/16/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 07/27/2016 (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 :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1988
(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.
03001
(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 ALL MINNESOTANS

Electronically delivered
July 5, 2016

Ms. Georgette Hinkle Administrator
Adams Health Care Center
810 West Main Street
Adams, Minnesota 55909

RE: Project Number S5509025

Dear :

On June 16, 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

<u>Informal Dispute Resolution</u> - 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:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
Health Regulation Division
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Telephone: (507) 206-2731
Fax: (507) 206-2711

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 26, 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 September 16, 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 December 16, 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.

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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245509	A. BUILDING ______ B. WING ______	06/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS HEALTH CARE CENTER	810 WEST MAIN STREET ADAMS, MN 55909

(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. 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 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 by: Based on observation, interview, and document review, the facility failed to ensure policies and procedures to ensure an environment that maintains dignity and respect for 1 of 1 residents (R31) reviewed for dignity. Findings included: During an interview on 6/13/16, at 2:57 p.m. R31 was conversing with surveyor with her door closed. R31 was sitting on the edge of her bed with her pajamas on, however the way she had sat up from a lying position left her upper thighs exposed. At 2:59 p.m. there was a knock on	F 241	Please note that our signature and response to CMS-2567 do not mean that we agree with either the tagged deficiency or the evidence presented to support any determination of non-compliance. We respond and provide a written plan of correction because the law requires it. -R31's newspapers are delivered by staff to the room on a daily basis as of 06/14/2016. -All newspapers to be received by any residents of Adams Health Care Center	7/13/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 07/13/2016

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.

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	245509	A. BUILDING ______ B. WING ______	06/16/2016

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F 241	Continued From page 1 R31's door and within a few seconds the door was opened and a male newspaper delivery person walked into the room without waiting for invitation to enter, announced the paper was here and set the paper on R31's bed. R31 stated, "I would appreciate it if they were invited in, instead of just coming in. They should wait for a response." During an interview on 6/14/16, at 1:55 p.m., activities director (AD)-A indicated the newspaper the resident received was delivered by the a delivery person to the resident rooms, however did not know which residents had a subscription to the paper. AD-A was not aware of any formal training provided for delivery people to ensure resident rights were not compromised. During an interview on 6/14/16, at 3:26 p.m. social worker (SS)-A indicated the newspaper office had left a message on her phone indicating the paper delivery person was an individual contractor and would need to follow the nursing homes policies for entering resident's rooms. SS-A then provided a facility policy dated 3/22/16 that instructed, "All deliveries for residents will be delivered to the front desk. No deliveries will be made to resident rooms." Facility policy Resident Rights, last reviewed 9/15 included, Federal and state laws guarantee certain basic rights to all residents of this facility. The policy indicated the right to privacy was included in the guaranteed rights. Resident Bill of Rights dated January 2016 includes, "The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups." The Bill of Rights also includes, "Facility staff shall	F 241	will be delivered by staff to their room daily. -All staff education will be held on 07/13/2016 to review policy on newspapers delivery and Resident Bill of rights with emphasis on Privacy and Confidentiality. -Newspapers deliveries will be monitored daily for one week, weekly for one month and monthly for 3 months. -Activity Director and/or Social Services Director are responsible to monitor for compliance. -Results will be forwarded to QA/QI Committee for review and further recommendation.	

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F 241	Continued From page 2 respect the privacy of a resident's room by knocking on their door by knocking on their door and seeking consent before entering, except in an emergency or where clearly inadvisable."	F 241		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure notification was given prior to a roommate change for 1 of 2 residents (R20) reviewed for admission, transfer and discharge. Findings include: R20 was interviewed on 6/14/16 at 9:46 a.m. R20 stated she had a new roommate she was not able to recall if she was given notice of a change in roommate. R20's quarterly Minimum Data Set dated 5/11/16 identified R20 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated R20 had moderate cognitive impairment. On 6/14/16 at 1:43 p.m. social services (SS)-A stated, " [R20] got a new roommate on 3/17/16 and was not notified. SS-A stated the process is as soon as we [the facility] received notification a new resident is moving in, the office staff up front chooses which room the new resident is moving in too. SS-A stated she was then responsible for	F 247	-R20 will receive notice of a new roommate every time it occurs. -All residents of Adams Health Care Center will receive notice of a new roommate at time of occurrence. -Nursing staff, Social Services and Activity Directors in-serviced regarding providing advance notice of a new roommate or room change per Adams Health Care Center Policy on 07/13/2016. -Weekly audits for one month and monthly audits for 3 months. -Administrator, Social Services and Activity Director are responsible to monitor for compliance. -Results will be forwarded to QA/QI Committee for review and further recommendation.	7/13/16

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F 247	Continued From page 3 informing the resident they were getting a new roommate and was responsible to document this in the medical record. SS-A stated in my absence the activity director completes the notification and documentation. " The facility's policy Room and Roommate Changes reviewed 8/2015 included: "It is the policy of Adams Health Care Center, and under guidelines of Medicare and Medicaid certified nursing homes, that all residents have rights concerning their room and roommate. Procedure: 2. All residents will be given notice when they will be receiving a new roommate."	F 247		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		7/13/16

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F 280	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise a care plan to include anxiety exhibited for 1 of 5 residents (R28) reviewed for unnecessary medications. R28 admitted to the facility on 12/9/15 with diagnoses that included major depressive disorder and generalized anxiety disorder according to the facility face sheet. R28's quarterly Minimum Data Set (MDS) dated 3/17/16 included diagnosis of anxiety disorder. R28's care plan provided by the facility on 6/16/16 lacked an individualized comprehensive care plan for managing anxiety. R28's physician orders included, Clonazepam 0.5 milligrams by mouth two times a day for generalized anxiety disorder. During an interview on 6/16/16, at 9:07 a.m. director of nursing indicated there should have been a care plan for anxiety. Facility policy was requested and not received.	F 280	-R28's care plan revised for management of anxiety and depressive disorders as of 06/16/2016. -All care plans for all residents of Adams Health Care Center will be developed and revised as needed to manage their disorders. -Nursing staff in-service education will be held on 07/13/2016 to review development and revision of individualized care plan. -Weekly audits for a month, and monthly for 3 months to check for compliance. -DON and/or her designee responsible to monitor for compliance. -Results will be forwarded to QA/QI Committee for review and further recommendation.	
F 282 SS=E	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 implement the plan of care as directed for 3 of 3 residents (R17, 16 & R55). For R17 not provided arm sleeve as care	F 282	-R16, R17 and R55 plans of care are implemented as of 06/16/2016. -Plan of care for all residents of Adams Health Care Center will be implemented	7/13/16

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F 282	Continued From page 5 planned, R16 for not grooming nails as care planned and R55 for not toileting vs. check and change as care planned. Findings include: SKIN PROTECTORS FOR ARMS NOT USED AS CARE PLANNED: R17 was admitted with diagnoses obtained from the most recent care plan dated 4/27/16, which included: chronic obstructive pulmonary disease, Type 2 Diabetes, atrial fibrillation, long term use of anticoagulants, Hypertension, Deficiency of specified B group vitamins and Vitamin D. Review of the 4/27/16 care plan identified R17 as having fragile skin and bruises easily with an intervention of "Geri sleeves to bilateral arms: daily to protect skin." Review of the Resident Profile: (individualized list for nursing staff to reference when providing care and documenting). Listed Skin: dated 4/27/2016: Geri sleeves to bilateral arms; daily to protect skin. Under the problem category: Activities of Daily Living (ADL) Functional/Rehabilitation Potential dated 4/27/2016: Approach: Resident prefers washing her upper arms herself due to very fragile skin to avoid bruising or skin tears. Review of the progress notes give repeated reference that R17 is able to communicate her needs, but there is no reference of refusal to wear Geri sleeves. During observation and interview on 6/14/16, at 1:45 p.m. R17 was seated in wheelchair (w/c) in her room watching TV. R17 was asked about the bruising on her bilateral arms and she stated that she bruised very easily and that she was not aware of staff monitoring bruising, but that they helped her every day so they wouldn't be able to miss the bruises. R17 further stated she bruised very easily because she was on a blood thinner. When asked about any protective measures she	F 282	as written. Nursing staff will receive education to review care plan implementation on 07/13/2016. -Random audits will be conducted weekly for a month, monthly for three months to check for compliance. -DON and/or her designee responsible to monitor for compliance. -Results will be forwarded to QA/QI Committee for review and further recommendations.	

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F 282	Continued From page 6 verbalized she was supposed to wear sleeves, but no one had offered to assist her to put them on. On 6/15/16, at 7:57 a.m. nursing assistant (NA)-A was observed assisting R17 to get up from bed, toilet and then provided personal cares and assisted with dressing for the day. NA-A assisted resident with cares and then stated she would have the nurse come in and apply wraps to R17's lower legs. R 17 was not offered the Geri sleeves and NA-A stated she was finished with her cares. 6/15/16, at 8:25 a.m. licensed practical nurse (LPN)-A entered R17's room, visited with her, applied ace wraps to bilateral lower legs, transported R17 from room to obtain a weight and then to the dining room, but made no mention/offer to apply Geri sleeves for R17. On 6/15/16, 8:35 am R17 stated she was supposed to be wearing Geri sleeves, but no one had offered to put them on for her and this happened most of the time. At 10:00 a.m. R17 was back in her room and then out to activities. No Geri-sleeves noted to be in place. At 12:27 p.m. R17 was noted to be in the dining room for the noon meal and continued to have no covering on bilateral arms. During an interview on 6/15/16, at 8:45 a.m. NA-A stated she was not aware R17 was supposed to wear Geri sleeves, so had not offered to apply them. During a subsequent interview on 6/15/16, at 8:48 a.m. LPN -A stated she was aware R17 was supposed to wear Geri sleeves, but she had not thought about offering to apply them when she did the leg wraps. The director of nursing was interviewed on 6/15/16, at 9:25 a.m. and confirmed R17 was supposed to be wearing bilateral Geri sleeves,	F 282		

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F 282	Continued From page 7 and she would have expected staff to offer to assist her with application and document in the record if refused. No documentation was provided indicating R17 had refused application of Geri sleeves. Review of the Policy and Procedure for the Prevention and Treatment of Skin Breakdown with a revision date of 9/21/15: Policy: it is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care. Resident Choice: In order for resident to exercise his/her right to appropriately make informed choices about care and treatment or to refuse treatment, the facility and the resident (or the legal representative) will discuss the resident's condition, treatment options, expected outcomes, and consequences of refusing treatment. The facility will address the resident's concerns ad offer relevant alternatives if the resident has refused treatments/interventions. This will be documented on the Refusal of Skin Care Interventions Risk and Benefit form per the Refusal of Skin Care Interventions Risk and Benefit Policy and Procedure. GROOMING OF NAILS NOT DONE TIMELY: R16 had been observed on 6/13/16 at 4:50 p.m., R16 was observed to have thick fingernails on both hands. All five nails on his left hand had dark debris underneath the nails. During an observation on 6/14/16 at 9:05 a.m., R16 was observed to have all thick nails on both hands. All five nails on his left hand had dark debris underneath them.	F 282		

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F 282	Continued From page 8	F 282		

During an observation on 6/15/16 at 9:09 a.m., nursing assistant (NA)-B assisted R16 with personal cares as he woke up from sleep. NA-B assisted with dressing R16 as well as taking to the toilet. NA-B then combed R16's hair and asked him if he would like to go have breakfast. NA-B then prepared to take R16 out to the dining hall. At that time, R16 was observed to have long, dark debris under fingernails on his left hand. R16's right hand had long fingernails.

During an observation on 6/16/16 at 8:30 a.m., R16 was sitting in the lobby. He was observed to have long fingernails on his right hand. The nails on his left hand were not observable as they were curled up.

R16's face sheet, dated 5/24/16, indicated that the resident had diagnoses of vascular dementia with behavioral disturbance and atrial fibrillation.

R16's physician order report, dated 6/2/16, indicated that the resident was to receive a weekly skin check along with nail care. It indicated that the resident was also on a blood thinning medication for atrial fibrillation.

R16's care plan, dated 5/24/16, stated that the resident was at risk for a self care deficit related to a right acetabulum fracture which was treated non-operatively. It stated that the resident needed extensive assistance with bathing, dressing and grooming. The care plan advised to assist with bathing, dressing and grooming daily.

R16's Minimum Data Set (MDS), dated 5/31/16, indicated that the resident had severe impairment in cognitive skills. It indicated that he required one staff to assist him with personal hygiene. It

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F 282	Continued From page 9 indicated that he had received anticoagulant (blood thinning) medication. When interviewed on 6/16/16 at 9:21 a.m., trained medication aide (TMA)-A stated that R16 had already had his bath this morning. When interviewed on 6/16/16 at 9:33 a.m., nursing assistant (NA)-C stated that any resident in the facility would have their nails trimmed on bath day once they got a bath. She stated that if a resident's nails were long they should be trimmed. When interviewed on 6/16/16 at 10:54 a.m., nursing assistant (NA)-D stated that she gave R16 a bath earlier in the morning. She stated that a resident's nails should be trimmed on bath days or if they are long they should be trimmed as needed. She stated that she did not trim R16's nails as she was told not to by the nursing staff as he was on blood thinning medication. She stated that she was told the nurse on duty would trim R16's nails. When interviewed on 6/16/16 at 12:37 p.m., licensed practical nurse (LPN)-A stated that only nurses were to trim fingernails for residents who were not diabetic. She stated that she had never heard of nursing assistants not able to trim nails because a resident was on a blood thinning medication. When interviewed on 6/16/16 at 1:37 p.m., trained medication aide (TMA)-A stated that the fingernails on both of R16's hands could be trimmed. She stated that the underneath the nails on both hands, "...were a little dirty." There was observed to be a hard substance underneath the	F 282		

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F 282	Continued From page 10	F 282		

fingernails on both hands. TMA-A was not sure if it was thickened nails or not as the hardened substance was underneath all the nails.

When interviewed on 6/16/16 at 1:37 p.m., licensed practical nurse (LPN)-A stated that she would soak R16's fingernails on both hands and trim the fingernails on both hands.

When interviewed on 6/16/16 at 2:02 p.m., the director of nursing (DON) stated that she told the nursing assistant not to trim R16's fingernails as a nurse should trim the nails. She stated that the nursing assistant should have told a nurse to trim the nails.

When interviewed on 6/16/16 at 2:25 p.m., licensed practical nurse (LPN)-A stated that they soaked R16's fingernails on both hands. She stated that there was dried food underneath all the fingernails that was removed. They soaked his nails and trimmed them and they were now clean.

Review of the facility policy titled, "Policy on Grooming/Hygiene" (revised 5/1/15), it stated that nails were to be cleaned and trimmed during bath days and PRN (as needed). It advised to inspect residents daily during cares for any additional grooming needs.

TOILETING CARE PLANNED BUT NOT CONSISTENTLY PROVIDED TO PREVENT INCONTINENCE:
R55's admission Minimum Data Set (MDS), dated 2/1/16, indicated that the resident was admitted to the facility on 1/25/16.

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F 282	Continued From page 11 R55's care plan, dated 5/3/16, indicated that the resident had urinary incontinence. The care plan recommended assisting the resident to use the toilet every three hours and as needed. It advised to provide incontinence care after each incontinent episode. When interviewed on 6/14/16 at 3:11 p.m., nursing assistant (NA)-G stated that R55 was incontinent of urine most of the time. NA-G stated that he toileted (the act of sitting on a fixture that flushes to remove waist or use of a commode) the resident by assisting the resident to his bed to change his incontinent brief. During an observation on 6/14/16 at 3:21 p.m., nursing assistant (NA)-G knocked on door and entered R55's room. R55 was seated in his wheelchair. NA-G retrieved the EZ Stand (a machine used to transfer patients) to assist R55 in transferring. NA-G assisted R55 to his bed and checked R55's incontinence brief for incontinence. NA-G stated that the brief was wet (urine), and, with gloved hands, changed R55's brief and cleaned up R55 while R55 was in bed. No toileting was offered or given according to the care plan. When interviewed on 6/16/16 at 2:00 p.m., the director of nursing (DON) agreed that the nursing assistants should not be only changing the incontinent brief of a resident but actually seating them on the toilet as care planned.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain	F 309		7/13/16

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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 309	Continued From page 12 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 record review, the facility failed to assess ongoing healing and determine if interventions to promote healing was affective for head wound for 1 of 1 resident (R40) who sustained skin tear on forehead after a fall which needed sutures. Findings include: R40 had been observed on 6/13/16, at 3:53 p.m. R40 was observed to have a quarter size scab on the right side of her forehead temple region. Located towards the top of the scabbed area showed short scratch like marks that were open however not draining. R40 reported she had a fall some time ago and the area had not yet healed completely and indicated she tends to pick at the scab. R 40's face sheet included diagnosis of diabetes type II, protein-calorie malnutrition, vitamin D deficiency, history of methicillin resistant staphylococcus aureus lesions (MRSA), and anxiety disorder. R40's significant change Minimum Data Set (MDS) indicated severe cognitive impairment with a Brief Interview of Mental Status Score of 4 and required limited assist from one staff for hygiene. R40's care plan dated 5/2/16 directed staff to monitor for signs and symptoms of skin breakdown related to history of systemic MRSA infection evidenced by history of MRSA lesions to left hand. The care plan also indicated R40 had	F 309	-R40's head wound (skin tear) was reassessed for ongoing healing on 06/15/2016 and order for new treatment was obtained on 06/15/2016. -Any residents of Adams Health Care Center who have wounds will be assessed/reevaluated for on-going healing and to determine if interventions to promote healing is effective. -Nursing staff education will be held on 07/13/2016 to review policy on wound/skin assessment and prevention and treatment of skin breakdown. -Audits will be conducted weekly for one month and monthly for three months to check for compliance. -DON and/or her designee responsible to monitor for compliance. -Results will be forwarded to QA/QI Committee for review and further recommendation.	

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	245509	A. BUILDING ______ B. WING ______	06/16/2016

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F 309	Continued From page 13 fragile skin. According to R40's progress notes the forehead injury occurred on 3/26/16 after falling in her bathroom and hitting her head. The injury required sutures. R40's progress notes reflect monitoring of the impaired skin integrity: on 4/2/16 the three sutures were removed. On 5/11/16 reported, "right forehead scab came off, slight bleed, foam dressing applied, change dressing every 3 days and as needed until healed." Progress note dated 5/25/16 mentioned the right forehead wound was healing however, lacked current assessment. R40's record indicated the wound was not monitored or assessed again until 6/15/16 during a physician visit. The physician wrote orders to apply Bactroban antibiotic ointment three times a day and cover with dressing until healed. During an interview on 6/15/16, at 2:00 p.m., registered nurse (RN)-B reported the wound on R40's forehead had not been assessed since 5/25/16. RN-B reported no monitoring had taken place since that time. RN-B reported the physician had seen R40 during rounds and gave new orders for wound treatment. During an interview on 6/16/16, at 9:12 a.m. director of nursing (DON) explained non-pressure related skin assessments performed weekly on a flowsheet, bruises monitored every shift daily until resolution, and skin tears were monitored once daily until healed. DON explained she had discontinued the dressing because the wound was healed, but unfortunately did not document in the medical record. Facility policy/procedure for Skin Check 9/17/14 directed licensed nurses to do a head to toe inspection on bath day and document changes in the progress notes, communicate changes of skin integrity team, physician, and family, update	F 309		

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F 309	Continued From page 14 the resident care plan, and for nursing assistants to check skin daily during cares and report changes.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of 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 ensure a resident received grooming assistance for nail care for 1 of 2 residents (R16) reviewed for activities of daily living (ADL's). Findings include: R16's 7 day Minimum Data Set (MDS), dated 5/31/16, indicated that the resident was admitted to the facility on 5/24/16. It indicated that the resident had severe impairment in cognitive skills. It indicated that he required one staff to assist him with personal hygiene. It indicated that he had received anticoagulant (blood thinning) medication. During an observation on 6/13/16 at 4:50 p.m., R16 was observed to have thick fingernails on both hands. All five nails on his left hand had dark debris underneath the nails. During an observation on 6/14/16 at 9:05 a.m.,	F 312	-R16's fingernails are trimmed per policy of Adams Health Care Center as of 06/16/2016 and ongoing. -All residents of Adams Health Care Center will have their nails trimmed per facility policy. -Nursing staff will receive education on 07/13/2016 to review grooming/hygiene policy. -Random audits will be conducted weekly for one month and monthly for 3 months to check for compliance. -DON and/or her designee responsible to monitor for compliance. -Results will be forwarded to QA/QI Committee for review and further recommendation.	7/13/16

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R16 was observed to have all thick nails on both hands. All five nails on his left hand had dark debris underneath them.

During an observation on 6/15/16 at 9:09 a.m., nursing assistant (NA)-B assisted R16 with personal cares as he woke up from sleep. NA-B assisted with dressing R16 as well as taking to the toilet. NA-B then combed R16's hair and asked him if he would like to go have breakfast. NA-B then prepared to take R16 out to the dining hall. At that time, R16 was observed to have long, dirty fingernails on his left hand. R16's right hand had long fingernails.

During an observation on 6/16/16 at 8:30 a.m., R16 was sitting in the lobby. He was observed to have long fingernails on his right hand. The nails on his left hand were not observable as they were curled up.

When interviewed on 6/16/16 at 9:21 a.m., trained medication aide (TMA)-A stated that R16 had already had his bath this morning.

When interviewed on 6/16/16 at 9:33 a.m., nursing assistant (NA)-C stated that any resident in the facility would have their nails trimmed on bath once they got a bath. She stated that if a resident's nails were long they should be trimmed.

When interviewed on 6/16/16 at 10:54 a.m., nursing assistant (NA)-D stated that she gave R16 a bath earlier in the morning. She stated that a resident's nails should be trimmed on bath days or if they are long they should be trimmed as needed. She stated that she did not trim R16's nails as she was told not to by the nursing staff as

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F 312	Continued From page 16 he was on blood thinning medication. She stated that she was told the nurse on duty would trim R16's nails. When interviewed on 6/16/16 at 12:37 p.m., licensed practical nurse (LPN)-A stated that only nurses were to trim fingernails for residents who were not diabetic. She stated that she had never heard of nursing assistants not able to trim nails because a resident was on a blood thinning medication. When interviewed on 6/16/16 at 1:37 p.m., trained medication aide (TMA)-A stated that the fingernails on both of R16's hands could be trimmed. She stated that the underneath the nails on both hands, "...were a little dirty." There was observed to be a hard substance underneath the fingernails on both hands. TMA-A was not sure if it was thickened nails or not as the hardened substance was underneath all the nails. When interviewed on 6/16/16 at 1:37 p.m., licensed practical nurse (LPN)-A stated that she would soak R16's fingernails on both hands and trim the fingernails on both hands. When interviewed on 6/16/16 at 2:02 p.m., the director of nursing (DON) stated that she told the nursing assistant not to trim R16's fingernails as a nurse should trim the nails. She stated that the nursing assistant should have told a nurse to trim the nails. When interviewed on 6/16/16 at 2:25 p.m., licensed practical nurse (LPN)-A stated that they soaked R16's fingernails on both hands. She stated that there was dried food underneath all the fingernails that was removed. They soaked	F 312		

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F 312	Continued From page 17 his nails and trimmed them and they were now clean. Review of the facility policy titled, "Policy on Grooming/Hygiene" (revised 5/1/15), it stated that nails were to be cleaned and trimmed during bath days and PRN (as needed). It advised to inspect residents daily during cares for any additional grooming needs.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive bladder assessment following a decline in incontinence for 1 of 1 resident (R55) reviewed for urinary incontinence. Findings include: R55's physician order report, dated 1/25/16, indicated that the resident had been prescribed Finasteride (used to treat symptoms of an enlarged prostate) and Flomax (a medication that	F 315	-A comprehensive bowel and bladder assessment was completed on 06/19/2016 for R55 -A comprehensive bowel and bladder assessment will be completed for all residents of Adams Health Care Center following a decline in incontinence. -Nursing Staff will be educated on 07/13/2016 to review bowel and bladder assessment completion when there is changes in incontinence. -Audits will be conducted weekly for one	7/13/16

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F 315	Continued From page 18 relaxes muscles in the bladder enabling easier urination) for an enlarged prostate. Also admitted to facility on 1/25/16. R55's admission Minimum Data Set (MDS), dated 2/1/16, indicated that the resident was found to be frequently incontinent of urine. Quarterly MDS dated 5/3/16 indicated incontinent was "always." R55's observation report, dated 2/22/16, stated that the resident was frequently incontinent of bladder. It stated that he was incontinent of bladder approximately every three to four hours. It recommended that staff assist the resident to the toilet every three hours and as needed. R55's progress notes, dated 3/4/2016, registered nurse (RN)-B wrote, Increased bladder incontinence noted. Will discuss with interdisciplinary team of significant change in incontinence. Need to determine if the change is related to an acute event foot infection or an actual change in activities of daily living. R55's progress notes, dated 03/04/2016, stated, "3 day bowel and bladder d/t [due to]changes since last assessment." The facility had no documentation that this was completed. Interdisciplinary team meeting (IDT) dated 3/10/16 included that the resident had no significant change at the time. He had an acute infection which was expected to resolve with a week or two. R55's care plan, dated 5/3/16, indicated that the resident had urinary incontinence. The care plan recommended assisting the resident to use the toilet every three hours and as needed. It advised	F 315	month and monthly for three months to check for compliance. -DON, MDS Coordinator responsible to monitor for compliance. -Results will be forwarded to QA/QI Committee for review and further recommendation.	

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to provide incontinence care after each incontinent episode. It also advised to report any signs of skin breakdown such as sore, tender, red or broken areas.

When interviewed on 6/14/16, at 2:56 p.m., nursing assistant (NA)-E stated that R55 was incontinent of urine. She stated that he was always incontinent. NA-E said, "When he first got here he would tell us if he needed to go to the bathroom." NA-E stated that his incontinent pad was always wet. She stated that R55's urinary incontinence had gotten worse since he had arrived in the facility.

When interviewed on 6/14/16 at 3:11 p.m., NA-G stated that R55 was incontinent of urine most of the time. NA-G stated that he toileted the resident by assisting the resident to his bed to change his incontinent brief.

During an observation on 6/14/16 at 3:21 p.m., NA-G knocked and entered R55's room. R55 was seated in his wheelchair. NA-G retrieved the EZ Stand (a machine used to transfer patients) to assist R55 in transferring. NA-G assisted R55 to his bed and checked R55's incontinence brief. NA-G stated that the brief was wet, and, with gloved hands, changed R55's brief and cleaned R55 up while he was in bed.

When interviewed on 6/16/16 at 10:22 a.m., registered nurse (RN)-B stated that when a resident had worsening urinary incontinence she would usually report it to the director of nursing. The situation would be reviewed with the interdisciplinary team who would then decide if it was due to an infection and just an isolated incident or if it was a real acute change. If an

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F 315	Continued From page 20 infection was ruled out and it was deemed an acute change then the nursing staff would then do a bowel and bladder assessment and from there review the plan of care. She stated that depending on the results of the bowel and bladder assessment, they would have changed the toileting schedule. RN-B stated that after R55 had continued to have continuous incontinent, no bowel and bladder assessment was done; furthermore, no plan of care was developed. RN-B stated that the facility had been trying to improve on this particular area as it is a quality indicator that the facility was monitoring. When interviewed on 6/16/16 at 2:00 p.m., the director of nursing (DON) stated that she had never been notified that R55 had worsening incontinence. She stated that if a resident were to develop worsening incontinence a bowel and bladder assessment would be done. She stated that it would be an expectation to do a bowel and bladder assessment and then to proceed from there. Review of the facility policy Bladder and Bowel Assessment Policy and Procedure dated 9/22/2010, it stated that a resident who was on a toileting program would be reviewed at least quarterly and with a significant change in continence status.	F 315		
F 329 SS=D	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	F 329		7/13/16

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F 329	Continued From page 21 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. 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 document review and interview, the facility failed to clearly identify target behaviors and mood behaviors to determine effectiveness of antidepressant and antianxiety medication for 1 of 5 residents (R28); failed to monitor for target behaviors for a prescribed antipsychotic for 1 of 5 residents (R12); failed to provide non-pharmacological measures prior to administration of an as-needed antianxiety medication for 1 of 5 residents (R12); failed to administer an as-needed antianxiety medication as indicated for 1 of 5 residents (R12); failed to conduct a sleep assessment for 1 of 5 residents (R12) who had been prescribed a medication used for sleep.	F 329	R28's target and mood behaviors are now clearly identified to determine the effectiveness of the antidepressant and antianxiety medications received. R12's target behaviors are monitored for the prescribed antipsychotic medication received, non-pharmacological measures are provided prior to administration of the as needed antianxiety medication and is receiving the as needed antianxiety medication as prescribed, and a sleep assessment was conducted on 06/16/2016. -Target and mood behaviors will be clearly identified to determine the effectiveness of psychotherapeutic received for all	

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F 329	Continued From page 22 Findings include: LACK OF IDENTIFYING TARGET BEHAVIORS AND MOOD SYMPTOMS TO DETERMINE EFFECTIVENESS OF PSYCHOACTIVE MEDICATIONS: R28 admitted to the facility on 12/9/15 with diagnoses that included major depressive disorder and generalized anxiety disorder according to the facility face sheet and was over 100 years old. R28's quarterly Minimum Data Set (MDS) dated 3/17/16 included diagnosis of anxiety disorder and depression. The MDS identified a mood score of 3 indicating minimal depressive symptoms. The MDS indicated R28 received anti-depressant and anti-anxiolytic (antianxiety) medications. R28's Care Area Assessment dated 12/16/15 indicated the use of antidepressant and antianxiety medications, a care plan would be developed, and the facility would monitor quarterly reviews as well as dose reduction. R28's physician orders on admission (12/9/15) included: · Clonazepam 0.5 milligrams (mg) by mouth two times a day for generalized anxiety disorder. · Effexor 150 mg once daily for major depressive disorder. · Mirtazapine (Remeron) 15 mg once daily at bedtime for major depressive disorder. Physician visit note dated 3/16/16 reported, "Patient is currently on Effexor XR 150 mg daily, Remeron 15 mg 1/2 tablet at bedtime, Clonazepam 0.5 mg 2 times daily for depression. BIMS (Brief interview for mental status) score is 1/27 on 12/16/15. R28's psychotropic medication review dated 3/25/16 indicated no behaviors had occurred since the time of admission with the exception of	F 329	residents of Adams Health Care Center. -All target behaviors for all prescribed antipsychotic medications received by residents of Adams Health Care Center are monitored, non-pharmacological measures are provided to residents prior to administration of as needed medications, as needed medications are administered as prescribed, and sleep assessment will be completed for all residents receiving sleep medication. -Nursing staff education will be held on 07/13/2016 to review policy on target behaviors, monitoring effectiveness of psychoactive medications, provision of non-pharmacological interventions prior to administration of psychoactive medications, administration of prescribed medications, and completion of sleep assessment to determine need for sleep medications. -Random audits will be conducted weekly for one month and monthly for three months to check for compliance. -DON and/or her designee responsible to monitor for compliance. -Results will be forwarded to QA/QI Committee for review and further recommendations.	

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F 329	Continued From page 23 one display of agitation shortly after R28's admission. Physician visit note dated 4/6/16 reported, "Patient has a long standing history of anxiety with depression. She has numerous medications [list of medications]. Resident specific target behavior is crying, depression statement, delusional thought. This has not occurred since she has been on her current medications since 12/9/15. Physician visit note dated 6/1/16 identified the use of Clonazepam, Effexor, and Mirtazapine and included, "There has been no dose reduction since admission on 12/9/15. Specific target behaviors: Yelling at staff, crying. Non-pharmaceutical approaches have been redirect, validating feelings, approach with different staff. Non-pharmaceutical approaches are effective at times." R28's target behavior monitoring included yelling at staff and crying. The target behaviors did not identify which medication(s) were being monitored for effectiveness. Behavior monitoring and progress notes from 3/1/16 through 6/15/16 were reviewed and did not reflect presence of target behaviors. During an interview on 6/16/16, at 9:07 a.m. director of nursing (DON) stated the behavior monitoring should have included which medication was being monitored for effectiveness. DON stated based off the target behavior monitoring it could not be determined which medication was associated with the target behavior. Facility policy Target Behavior Monitoring dated 9/18/16 included, "For each psychotherapeutic med [medication] administered, there will be at least one target behavior that is monitored. Target behavior/s will be monitored every shift. Target	F 329		

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behavior/s will be documented in the care plan. Appropriate diagnosis will be obtained and behavioral symptom/s that are being treated will be documented." The policy also included, "Psychotherapeutic med assessment will be completed to determine need for med."
DID NOT ATTEMPT NONPHARMACOLOGICAL INTERVENTIONS BEFORE GIVING ANTIANXIETY MEDICATION AND GAVE MEDICATION WITHOUT CLEAR AND RESIDENT SPECIFIC INDICATIONS FOR USE:

R12's face sheet, dated 12/4/2012, indicated that the resident had diagnoses of: anxiety, major depressive disorder and psychosis.

R12's physician order report, dated 5/12/16, indicated that the physician had prescribed Ativan (an antianxiety medication): 0.5 mg (milligram) were to be taken three times a day as needed for anxiety or air hunger.

R12's care plan, dated 5/12/16, stated that the resident was taking psychotropic medication and was at risk for side effects due to taking these medications. It recommended, "Assess for efficacy [sic] by sleep habits, mood, behavior changes, restlessness, anxiety, appetite. Report to nurse as needed."

R12's behavior administration history, reviewed from 5/1/16 through 6/16/2016, indicated that the facility had identified target behaviors that they were monitoring included: depressive statements (initiated on 5/20/16), excessive call light use (initiated on 5/20/16), rude comments (initiated on 4/14/16), spitting phlegm on the floor (initiated on 5/20/16), throwing garbage on the floor (initiated on 5/20/16), yelling for staff (initiated on 5/20/16)

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	245509	A. BUILDING ______ B. WING ______	06/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS HEALTH CARE CENTER	**810 WEST MAIN STREET ADAMS, MN 55909**

(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
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and swearing at staff (initiated on 4/12/16).

R12's medication administration history (MAR), reviewed from 5/12/16 through 6/16/16, indicated that the resident had been administered an as-needed dose of Ativan a total of fifty-three times. The majority of the time it was administered for the purposes of anxiety. It did not describe what this anxiety was. Other times it was administered for either the purposes of sleep or pain which were not indicated for use of the ativan. Only once was it administered for shortness of breath. Of all these times between 5/12 and 6/16/16, the staff did not provide non-pharmacological measures prior to the administration of Ativan.

When interviewed on 6/16/15 at 10:07 a.m., nursing assistant (NA)-F was asked what behaviors R12 had exhibited that she had been instructed to notify the nursing staff. She stated that R12 would yell a lot or yell for help if he was in the bathroom. He would pull the cord in the bathroom and then start yelling right away. She stated that he would typically yell two to four times an hour. NA-F described how R12 would yell while in bed. Some of the reasons he would yell for staff were that he was not able to breathe or can't get to the toilet or even if he would need a pillow adjusted. NA-F stated that R12 did have a lot of shortness of breath.

When interviewed on 6/16/16 at 9:31 a.m., NA-C was asked what behaviors R12 exhibited that she had been instructed to notify the nursing staff in order to document. She stated that R12's main behavior was constantly yelling for help.

When interviewed on 6/16/16 at 1:02 p.m.,

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licensed practical nurse (LPN)-A stated that R12's anxiety was manifested by his constant yelling at staff.

When interviewed on 6/16/16 at 2:14 p.m., the director of nursing (DON) stated that the nursing staff should have been providing non-pharmacological measures prior to the administration of an as-needed antianxiety medication.

LACK OF IDENTIFYING TARGET BEHAVIORS AND MONITORING THESE TO DETERMINE EFFICACY OF ANTIPSYCHOTIC MEDICATION:

R12's pharmacy review, dated 4/21/16, indicated that the pharmacist recommended a more appropriate diagnosis for the use of Seroquel. The physician had responded that the Seroquel should be used for psychosis and hallucinations.

R12's physician order report, dated in April 2016, indicated that the resident had been prescribed Seroquel (an antipsychotic medication). He was to take 12.5 mg (milligrams) twice daily for anxiety.

R12's medication administration history (MAR), reviewed 4/1/16 through 6/16/16, indicated that the resident had been taking the Seroquel as prescribed.

R12's pharmacy review, dated 4/21/16, indicated that the pharmacist recommended a more appropriate diagnosis for the use of Seroquel. The physician had responded that the Seroquel should be used for psychosis and hallucinations.

When interviewed on 6/16/2016 at 1:02 p.m.,

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licensed practical nurse (LPN)-A stated that R12 received the Seroquel for anxiety. She stated that R12 had a longstanding history of making depressive statements, constantly pressing the call light, spitting on the floor, throwing things on the floor. She stated that the indication for the use of the Seroquel was for anxiety. She stated that the facility was not monitoring for any psychotic behavior or hallucinations.

When interviewed on 6/16/16 at 2:14 p.m., the director of nursing (DON) stated that the facility had not been monitoring R12's hallucinations.

LACK OF A COMPREHENSIVE SLEEP ASSESSMENT TO DETERMINE NEED FOR MELATONIN:

R12's physician order report, dated 6/2/2016, indicated that the resident had been prescribed melatonin (a medication used for sleep). He was to take 3 mg (milligrams) by mouth for sleep.

R12's medication administration record, reviewed for June 2016, indicated that the resident had been taking this medication.

R12's medical record did not contain a sleep assessment.

When interviewed on 6/16/16 at 2:14 p.m., the director of nursing (DON) agreed that a sleep assessment should have been completed prior to the administration of a sleep-aid medication.

When interviewed on 6/16/16 at 2:42 p.m., the pharmacist stated that the strategy behind the use of the Ativan was for R12's COPD (chronic obstructive pulmonary disease). He stated that he

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F 329	Continued From page 28 agreed that the Ativan should be used as prescribed and if R12 was using it for sleep, well then, why was he not sleeping? The pharmacist stated that the facility should be monitoring for hallucinations. Review of the facility policy for as needed medications, dated 11/5/15, it stated that an as needed medication must contain an indication for use. It stated that each as-needed medication must be documented in the medication administration record and must contain documentation of effectiveness. Review of the facility policy for target behavior monitoring, dated 9/18/2014, it stated that for each psychotherapeutic medication administered, there would be at least one target behavior that was to be monitored. Target behaviors would be monitored each shift and would be documented in the care plan. It stated that prior to the administration of psychotherapeutic medications, an appropriate diagnosis would be obtained and behavioral symptoms that were being treated were to be documented. Review of the facility policy for sleep assessments, not dated, it stated that a sleep assessment would be performed on residents to establish baseline data on admission and then annually for residents who receive hypnotics and for any resident having difficulty with sleeping.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428		7/13/16

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F 428	Continued From page 29 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow pharmacist recommendations for gradual dose reduction and failed to ensure the consulting pharmacist identified lack of a plan of care for anti-anxiety medication and identify resident centered target behaviors associated with psychotropic medications for 1 of 5 residents (R28). Findings include; R28 admitted to the facility on 12/9/15 with diagnoses that included major depressive disorder and generalized anxiety disorder according to the facility face sheet and over 100 years old. R28's quarterly Minimum Data Set (MDS) dated 3/17/16 included diagnosis of anxiety disorder and depression. The MDS identified a mood score of 3 indicating minimal depressive symptoms. The MDS indicated R28 received anti-depressant and anti-anxiolytic medications. R28's Care Area Assessment dated 12/16/15 indicated the use of antidepressant and antianxiety medications, a care plan would be developed, and the facility would monitor quarterly reviews as well as dose reduction. R28's care plan provided by the facility on 6/16/16	F 428	R28's target behaviors are clearly identified for the psychotropic medication associated with them. Pharmacy Consultant's recommendations for gradual dose reduction are followed and care plans for psychoactive medications are developed and implemented. -Nursing staff education will be held on 07/13/2016 to review policy on target behaviors, follow-up on pharmacist recommendations, and care plan development and implementation for psychoactive medications. -Audits will be conducted weekly for one month and monthly for three months to check for compliance. -DON and/or her designee responsible to monitor for compliance. -Results will be forwarded to QA/QI Committee for review and further recommendations.	

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F 428	Continued From page 30 lacked an individualized comprehensive care plan for managing anxiety. R28's care plan for psychotropic medications identified use of antianxiety and antidepressant medications and included the goal, "resident will be prescribed the lowest effective dose of medication." R28's most current physician orders included: · Clonazepam 0.5 milligrams (mg) by mouth two times a day for generalized anxiety disorder. Start date 12/09/15 · Effexor 150 mg once daily for major depressive disorder. Start date 12/09/15. · Mirtazapine (Remeron) 15 mg once daily at bedtime for major depressive disorder. Start date Start date 12/09/15 Physician visit note dated 3/16/16 reported, "Patient is currently on Effexor XR 150 mg daily, Remeron 15 mg 1/2 tablet at bedtime, Clonazepam 0.5 mg 2 times daily for depression. BIMS (Brief interview for mental status) score is 1/27 on 12/16/15. It should be noted that patient has been on these medications for several years and trying to decrease the dose of these medications worsens her depression and anxiety." R28's psychotropic medication review dated 3/25/16 indicated no behaviors had occurred since the time of admission with the exception of one display of agitation shortly after R28's admission on 12/09/15. Physician visit note dated 4/6/16 reported, "Patient has a long standing history of anxiety with depression. She has numerous medications [list of medications]. Resident specific target behavior is crying, depression statement, delusional thought. This has not occurred since she has been on her current medications since 12/9/15. Non pharmaceutical approaches have been tried. They are effective at times."	F 428		

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F 428	Continued From page 31 Physician note indicated the mood score of 3 on 3/7/16 and medical and environmental factors have been ruled out. R28's pharmacy review dated 5/25/16 indicated a request for a dose reduction for any agent. The physician responded by stating previous dose reduction failures with increase in worsening depression and hospitalization. The note from the physician did not indicate which medication had been reduced, when it was reduced, or what it was reduced to. During an interview on 6/16/16, at 9:07 a.m. director of nursing (DON) stated the only medication that had a previous dose reduction was Effexor on 9/27/14 when R28 resided in assisted living. DON stated the dose reduced by 75 mg per day to 150 mg per day (current dose). DON stated there was no evidence of a historical failed dose reduction in the record that she could find. DON stated there should have been a gradual dose reduction attempted based off the documentation. Physician visit note dated 6/1/16 identified the use of Clonazepam, Effexor, and Mirtazapine and included, "There has been no dose reduction since admission on 12/9/15. Specific target behaviors: Yelling at staff, crying. Non-pharmaceutical approaches have been redirect, validating feelings, approach with different staff. Non-pharmaceutical approaches are effective at times." R28's target behavior monitoring included yelling at staff and crying. The target behaviors did not identify which medication(s) were being monitored for effectiveness. Behavior monitoring and progress notes from 3/1/16 through 6/15/16 did not reflect presence of target behaviors. During an interview on 6/16/16, at 9:07 a.m. director of nursing (DON) stated the behavior	F 428		

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F 428	Continued From page 32 monitoring should have included which medication was being monitored for effectiveness. DON stated based off the target behavior monitoring it could not be determined which medication was associated with the target behavior. DON also indicated R28 should have had an anxiety care plan. During an interview on 06/16/16, at 10:43 a.m., consulting pharmacist (CP)-A stated should be a care plan for anxiety. indicated behaivor moniotring should be associated with a medication to determine effectiveness of medication. Facility policy Target Behavior Monitoring dated 9/18/16 included, "For each psychotherapeutic med administered, there will be at least one target behavior that is monitored. Target behavior/s will be monitored every shift. Target behavior/s will be documented in the care plan. Appropriate diagnosis will be obtained and behavioral symptom/s that are being treated will be documented." The policy also included, "Psychotherapeutic med assessment will be completed to determine need for med."	F 428		

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

F5509024

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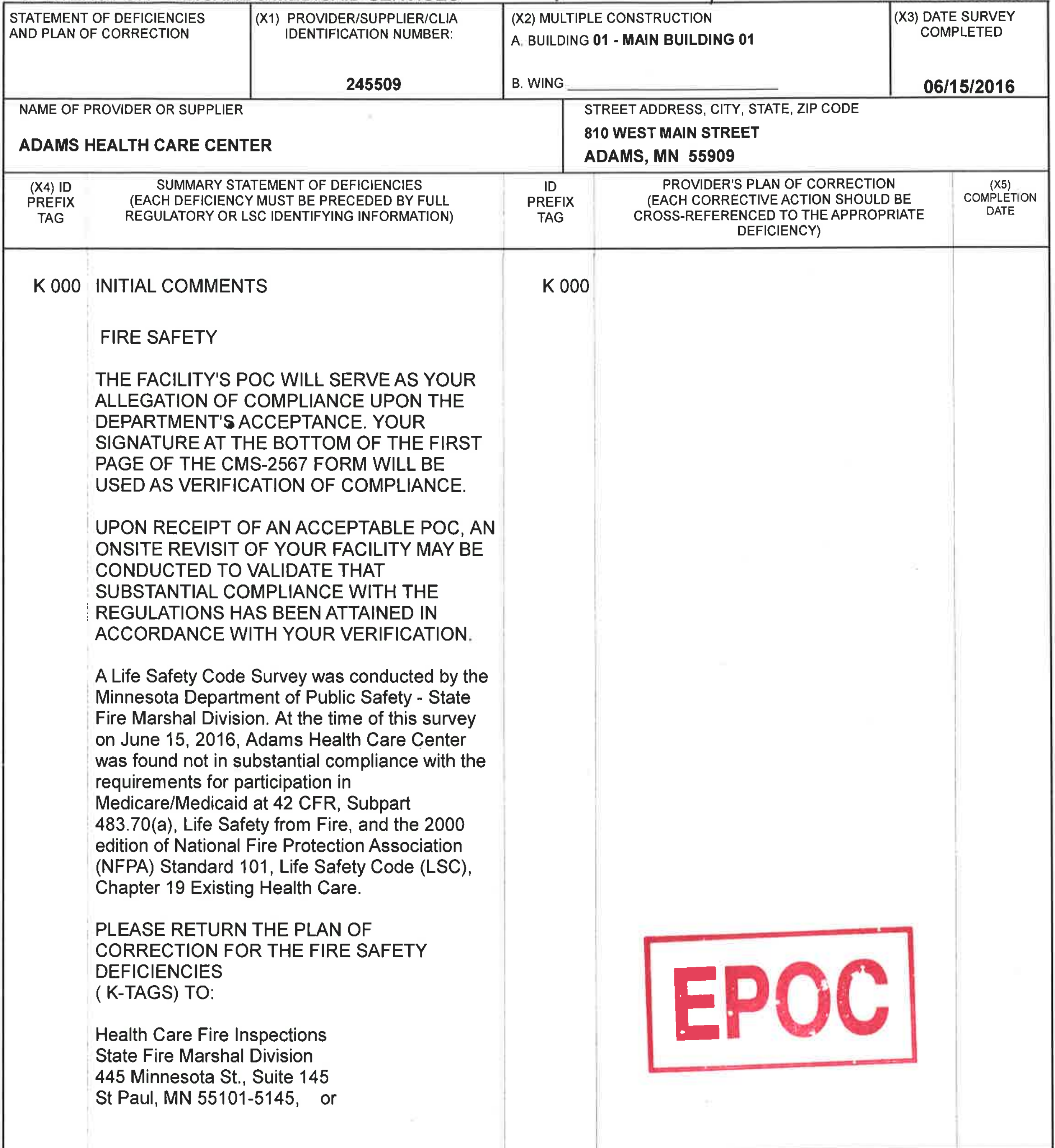
FORM APPROVED
OMB NO. 0938-0391



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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. At the time of this survey on June 15, 2016, Adams Health Care Center 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/08/2016

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.

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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.

The Adams Health Care Center is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1976 and determined to be of Type II(111) construction. In 1992, an addition was constructed and determined to be of Type II (111) construction..

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES
(K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St Paul, MN 55101-5145, or

By email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

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K 000	Continued From page 2 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. The facility is fully sprinklered. The facility has a fire alarm system with partial smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 49 beds and had a census of 43 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames.	K 025	Please note that our signature and response does not mean that we agree with either the tagged deficiency or the evidence presented to support any determination of non-compliance. We respond and provide a written plan of correction because the law requires it.	6/16/16

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K 025	Continued From page 3 8.3, 19.3.7.3, 19.3.7.5 On facility tour between 09:30 AM and 12:30 PM on June 15, 2016, observation revealed that there were penetrations in smoke barriers above ceilings next to room 123 and the nurses station area.	K 025	-The open penetrations in smoke barriers above ceiling next to room 123 and the nurses station area were sealed on 06/16/2016. The Environmental Director and/or designee are responsible to monitor for compliance.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 On facility tour between 0930 AM and 12:30 PM on June 15,2016, observation that there are no fire sprinkler protection in closets for office 138 and 139.	K 056	The bifolds doors in closets for office 138 and 139 were removed on 06/16/2016. The Environmental Director and/or designee are responsible to monitor to prevent reoccurrence.	6/16/16

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS HEALTH CARE CENTER	**810 WEST MAIN STREET** **ADAMS, MN 55909**

(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