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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 4TO6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00405

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245547**
2.STATE VENDOR OR MEDICAID NO.
(L2) **292923000**

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

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

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

6. DATE OF SURVEY **01/29/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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
	30			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 02/06/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: MPM
Mark Meath, Enforcement Specialist 04/10/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00320 (L31)

30. REMARKS
Posted 04/10/2014 CO.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
02/14/2014 (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

CCN-245547

Adrian Care Center was not in substantial compliance with Federal participation requirements at the time of the standard survey completed on December 12, 2013. January 29, 2014, the Departments of Health and Public Safety completed a Post Certification Revisit (PCR) health deficiencies by review of the plan of correction. Based on the PCR, it has been determined that the facility achieved substantial compliance pursuant to the December 13, 2013 standard survey, effective January 20, 2014. Refer to the CMS-2567b for both health and life safety code.

Effective January 20, 2014 the facility is certified for 30 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5547

April 10, 2014

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

Dear Ms. Baker:

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

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

Effective January 20, 2014 the above facility is certified for:

30 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 6, 2014

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

RE: Project Number S5547023

Dear Ms. Baker:

On December 30, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 12, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F)whereby corrections were required.

On January 29, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 29, 2014 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 December 12, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 20, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 12, 2013, effective January 20, 2014 and therefore remedies outlined in our letter to you dated December 30, 2013, 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. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Kathy Serie, Unit Supervisor
Licensing and Certification Program
Telephone: 507-537-7158 Fax: 507-344-2723

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245547	A. Building B. Wing	1/29/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **01/20/2014**	ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **01/20/2014**	ID Prefix **F0250** Reg. # **483.15(g)(1)** LSC	Correction Completed **01/20/2014**
ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **01/20/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **01/20/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **01/20/2014**
ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **01/20/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **01/20/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **01/20/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/KS	04/10/2014	03048	01/29/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/12/2013			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245547	A. Building B. Wing 01 - MAIN BUILDING 01	1/29/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 01/17/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By MM/PS	Date: 04/10/2014	Signature of Surveyor: 22373	Date: 01/29/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 12/11/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245547	A. Building B. Wing 02 - 2009 LINK TO ASSISTED LIVING	1/29/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 01/17/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By MM/ PS	Date: 04/10/2014	Signature of Surveyor: 22373	Date: 01/29/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 12/11/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 4TO6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00405

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

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

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

4. TYPE OF ACTION: **2** (L8)
1. Initial — **2. Recertification**
3. Termination — 4. CHOW
5. Validation — 6. Complaint
7. On-Site Visit — 9. Other
8. Full Survey After Complaint

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

6. DATE OF SURVEY **12/12/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Kathy Hahn, HFE NE II — 01/24/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 02/03/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN-245547

At the time of the standard survey completed December 12, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed.

Also, see attached Fire Safety Evaluation System (FSES) for Life Safety Code results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7246

December 30, 2013

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

RE: Project Number S5547023

Dear Ms. Baker:

On December 12, 2013, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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:

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

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

<u>Remedies</u> - 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;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 East Lyon Street
Marshall, MN 56258-2529

Office: (507) 537-7158
Fax: (507) 537-7194

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 January 21, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 21, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following 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 PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 March 12, 2014 (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 June 12, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
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
	245547	A. BUILDING _____ B. WING _____	12/12/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157	**F 157** R17's previous eye infection has resolved without incident. All residents who have changes in status or changes in treatments shall have the appropriate contacts informed of the changes. The DON or designee will review 100% of all resident progress note entries daily. Should any entry indicate a noted change of status, the DON or designee shall initiate the Clinical Monitoring protocol and assure immediate notification of the appropriate contact[s]. These contacts will be documented in the progress notes of the EMR.	

approved KMS 1/23/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Scott Kessler — TITLE: Administrator — (X6) DATE: 1/15/14

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

RECEIVED
JAN 23 2014
Minnesota Department of Health
Marshall

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F 157	Continued From page 1 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the family of a change in condition for 1 of 3 residents (R17) reviewed whose legal representative required notification of status changes. Findings include: R17 had a Brief Interview for Mental Status (BIMS) assessment score of 3 on the quarterly Minimum Data Set (MDS) assessment, dated 10/19/13, indicating severe cognitive impairment. The care plan, dated 4/14/13, identified R17 with cognitive loss/dementia, impaired decision making and was not aware of place or time. During an interview with R17's family member (F)-A on 12/10/2013 at 10:49 a.m., it was stated the F-A had not been notified after R17 had developed an eye infection. F-A stated the eye infection was noted by the family during a visit. During interview with the director of nursing (DON) on 12/11/13 at 12:30 p.m. it was stated R17's daughter was notified of changes in family member's condition via phone calls from the staff nurse. The DON stated she was unaware that R17 had experienced an eye infection in the past	F 157	All staff responsible for documenting resident status in the EMR progress notes will be educated on the protocol changes with revision & review of all corresponding policy & procedures by 1/20/14. Daily audits will compare the Clinical Monitoring tool, progress notes and shift reports to assure changes are noted, documented & communicated as needed. The DON or designee shall do these audits daily for 7 days or longer until all staff are well versed in the new procedures. Thereafter, audits will be completed 1X weekly, X60 days. All outcome audits will be presented to the QAA Committee for review &/or comment.	

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F 157	Continued From page 2 year but had experienced an upper respiratory infection and developed a cold sore. During medical record review it was noted in the nursing progress note, dated 8/21/13 that R17 had redness in both eyes, with green drainage in the left eye. Documentation in the progress note further identified that R17 complained of "burning" eyes and an antibiotic (Gentamycin) eye drop was started on 8/22/13 after a diagnosis of conjunctivitis (eye infection). Documentation in the nursing progress note, dated 08/27/2013, indicated R17 had slight redness to both eyes with absence of burning or itching. There was no documentation to indicate the family had been notified of the eye infection. During interview with F-A on 12/11/13 at 1:30 p.m. it was confirmed the staff had never contacted the family regarding the eye infection that R17 experienced in August. According to the medical record, F-A was identified as the responsible party for R17. During further interview with the DON on 12/11/13 at 2:30 p.m. she verified the medical record identified that R17 had developed an eye infection. She confirmed that documentation was lacking to indicate the family/responsible party had been notified of the infection nor of the subsequent antibiotic eye drop treatment. The facility policy "Family Responsible Party Notification", dated 10/24/2008, identified the resident responsible party was to be notified anytime there is a change in condition, change in medication, change in mental, psychological or behavior management or any other time there had been a change in the resident plan of care.	F 157		

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F 157	Continued From page 3 The designated person on the face sheet will be the contacted party. Procedure 3.3 directs staff to document in the resident's medical record, the time called, the person spoke with, what was reported and their response if any. Procedure 3.5 directs staff to document each time they called.	F 157		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to resolve grievances involving missing dentures for 1 of 1 resident (R17) whose family identified the missing personal property. Findings include: R17 was admitted on 4/14/13. The initial care plan, dated 4/14/13, had identified that R17 required one staff assist with oral hygiene related to dementia and that R17 had upper and lower dentures. The quarterly Minimum Data Set (MDS) assessment, dated 10/19/13, identified R17 with severe cognitive impairment. During a family interview on 12/10/13 at 10:40 a.m., family (F)-A stated R17's dentures were missing shortly after admission on 4/14/13. F-A indicated the facility staff had been informed of the missing dentures, but no follow up occurred.	F 166	**F 166** Resident R17 condition has declined and no longer uses dentures. DON has discussed this with the family. The Center's current policy & procedure was reviewed and revised as needed. All residents and/or families that report resident personal items shall have a missing item form completed immediately. The form will be immediately forwarded to the Administrator for further action/interviews. The missing item protocol shall be explained at each Resident Council Meeting and the same information shall be provided to new admissions & their primary contacts. Social Service designee will provide and document this informational exchange in the EMR. All staff in the Center shall be educated on the revised protocols by 1/20/2014. Administrator or designee shall audit all new admissions for 90 days and Resident Council meeting minutes monthly for 90 days for compliance with the protocols. All audit outcomes shall be presented to the QAA Committee for review and comment.	1/20/14

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F 166	Continued From page 4 During an interview with the DON on 12/10/13 at 3:20 p.m., she stated R17 was admitted with both upper and lower dentures. She also stated the responsible party is encouraged to fill out a personal inventory list upon admission. The DON verified that R17's family had reported missing dentures but was unsure whether the dentures were missing after or prior to admission. Interview with nursing assistant (NA)-C on 12/10/13 at 4:00 p.m., identified that R17 was admitted with only the upper dentures. On 12/11/13 at 12:00 p.m., the DON stated she was unable to find any personal inventory list in R17's chart. She verified the care plan indicated that R17 had both upper and lower dentures on admission, but that the care plan was incorrect. Upon further interview on 12/11/13 at 1:55 p.m., F-A verified that R17 had dentures when admitted to the facility but were lost after admitted. F-A also verified the missing dentures had been reported but no follow up nor resolution to the complaint had occurred. On 12/11/13 at 2:30 p.m., the DON verified that documentation related to the missing personal property was not available. The DON also verified the missing dentures had been reported to administration without follow-up and/or resolution to the grievance voiced. Review of the facility's policy for missing/lost items indicated that in the event of a lost item, the resident and/or responsible party should report the lost item to administration immediately. An immediate internal investigation will be conducted	F 166		

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F 166	Continued From page 5 by administration and a response to the report will be provided within 5 business days.	F 166		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide medically-related social needs for 1 of 1 resident (R20) reviewed who had exhibited ongoing behavioral issues. Findings include: During an observation of R20 at 5:10 p.m. on 12/9/13, R20 was yelling out in the dining room. At 5:12 p.m. staff brought R20 her supper meal, R20 took a few bites of food and pushed the plate away. At 5:15 p.m. R20 continued to yell out in the dining room without any staff intervention. Two tablemate's kept staring at R20 during this time. At 5:20 p.m. a nursing assistant (NA)-A sat down to assist the resident with eating. At 5:41 p.m. the NA-A asked the resident "Are you done? " It was noted that staff never addressed the continued yelling nor inquired if R20 was in need of anything. During an observation on 12/11/13 at 9:00 a.m., R20 was heard to intermittently yell out while she was seated at a table in the dining room. During continued observations, R20 was noted to	F 250	**F 250** R20's record has been reviewed and add'l interventions will be attempted to decrease her yelling out with an analysis of the effectiveness of the interventions. All residents receiving psychoactive medications shall have target behaviors identified on the plan of care. These behaviors shall be recorded as they occur and monthly, the Social Services Director shall complete an analysis of the behavior with an evaluation of intervention effectiveness. 100% of all residents with behaviors shall have their care plans reviewed for identified target behavior monitoring with proven or trial interventions to decrease behavioral symptoms. Analysis of the target behaviors and the effectiveness of interventions shall be reviewed and analyzed monthly for residents with acute or ongoing behavioral issues X 90 days. Information regarding the analysis shall be communicated to the RPh and/or medical provider for review and recommendations.	

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F 250	Continued From page 6 continue to yell out until 10:00 a.m. when staff transported R20 back to her room. Staff were not observed to attempt any behavioral interventions during the time R20 was yelling out. During lunch observations on 12/11/13 from 11:30 a.m. until 12:10 p.m., R20 yelled out as she ate in the dining room with staff assistance. On 12/12/13 at 9:15 a.m., R20 was observed yelling out and staff did not address the behavior nor implement any individualized interventions. R20 had diagnoses which included: Alzheimer's disease, depression, anxiety, and psychosis. A quarterly Minimum Data Set (MDS) assessment dated 10/30/13, indicated R20 had impaired memory with severely impaired decision making. In addition, the MDS also indicated R20 required extensive assistance with activities of daily living, and exhibited behavioral symptoms 1-3 days/week. The care plan dated 6/23/13 and titled " behaviors " addressed that R20 had socially inappropriate and disruptive behaviors and the goal identified for this behavior included "loud and yelling noises will occur less than 2 times per day". Interventions included: provide activities for resident one on one basis, avoid over stimulation, administer medication, maintain a calm environment and approach the resident. The plan also indicated that when R20 became socially inappropriate, staff were to provide comfort measures for basic needs. During review of nursing notes and behavior monitoring reports, intermittent behaviors were documented which included yelling out. There	F 250	All staff responsible for behavioral documentation shall be educated on the new protocols by 1/20/14. The Administrator or designee shall review all resident records to assure monthly behavioral analysis has been completed q month X 90 days or longer until 100% compliance has been achieved. Audit outcomes shall be presented to the QAA Committee for review and comment.	1/20/14

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F 250	Continued From page 7 were no progress notes nor were evaluations evident in the medical record related to the resident's response to any planned behavioral interventions. On 12/12/13 at 9:00 a.m. during an interview with the director of nursing (DON), she verified that R20 does yell out intermittently. The DON verified that resident response to planned behavioral interventions was lacking in the medical record so that interventions could be evaluated for effectiveness and so revisions could be made.	F 250		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money	F 278	**F 278** Resident R19's MDS has been corrected to address her contracture of the right hand & wrist. Her overall plan of care has been reviewed and revised to reflect her current rehabilitation needs. All residents with confirmed or potential impairments due to contractures have been reviewed and appropriate nsg. rehab modalities have been established. Their respective care plans have been updated to reflect the modalities. All staff providing evaluation, oversight and direct rehab modalities have been educated on the process by 1/20/14.	

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F 278	Continued From page 8 penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to conduct an accurate assessment related to range of motion (ROM) for 1 of 1 resident (R19) who had a right hand and wrist contracture. Findings include: R19 had an annual care area assessment (CAA) dated 4/7/13 which failed to identify any limitation with upper or lower extremity ROM. The most recent quarterly Minimum Data Set (MDS), dated 10/8/2013, also indicated R19 had no impairment in upper extremity function. On 12/10/2013 at 2:00 p.m., R19 was observed to have a contracture in her right hand and wrist. Interview with licensed practical nurse (LPN)-A on 12/10/13 at 2:00 p.m. verified that R19 had a contracture to the right hand and wrist. Nursing assistant (NA)-C stated that R19 did not receive any ROM during cares. On 12/10/2013 at 2:55 p.m. during an interview with the physical therapy assistant (PTA), it was indicated that R19's right hand was "a little stiff" and that R19 would benefit from therapy and exercises. On 12/10/13 at 3:00 p.m., the director of nursing	F 278	The DON or designee shall review all resident records for completed rehab modalities weekly X 30 days to assure compliance. Thereafter, audits will be completed 2X month for 60 days or until 100% compliance is achieved. These audit summaries shall be submitted to the QAA Committee for review &/or comment.	1/20/14

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F 278	Continued From page 9 (DON) verified that R19 had a contracted right hand and wrist that should be evaluated. The DON stated that the trained medication assistant (TMA) conducted restorative therapy 3 times a week but did not perform any restorative exercises with R19 and further indicated the noted ROM had not declined since admission. The DON confirmed the initial assessment dated 4/7/13 and the quarterly assessment dated 10/8/13 had not accurately reflected the range of motion status of R19.	F 278		
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. This REQUIREMENT is not met as evidenced by:	F 280	**F 280** R17's care plan has been updated to reflect her current dental status. All resident care plans have been reviewed and revised as needed to reflect current ADL needs. All staff who provide resident cares have been educated on the importance of following the plan of care and if differences are noted, to report to charge personnel that a change has occurred. Date of compliance will be 1/20/14. The DON or designee will audit all care plans to assure all ADL needs are addressed. Thereafter, care plans will be updated as changes occur but no less than quarterly. Audit data will be presented to the QAA Committee for review and/or comment.	1/20/14

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F 280	Continued From page 10	F 280		

Based on observation, interview and document review the facility failed to revise the care plan for 1 of 3 residents (R17) reviewed for dental hygiene.

Findings include:

R17's care plan, dated 4/14/13 identified that she required assistance of one staff with oral hygiene related to the diagnosis of dementia. The care plan further indicated that R17 had both upper and lower dentures.

During observations throughout the four days of survey, 12/9/13, 12/10, 12/11 and 12/12/13, upper and lower dentures were not evident in R17's mouth. On 12/10/13 at 1:30 p.m. R17's upper dentures were observed to be located in a white plastic container, soaking in water on the top shelf of the medicine cabinet in her room.

During interview with nursing assistant (NA)-C on 12/10/13 at 4:00 p.m., NA-C stated R17 did not wear the dentures and stated the lower dentures had been missing for a long time.

During an observation on 12/11/13 at 9:30 a.m. NA-A and NA-B assisted R17 with morning cares. NA-A and NA-B completed cares and did not place R17's dentures into her mouth. NA-A stated R17 "no longer" wore her dentures.

During interview with the director of nursing (DON) on 12/11/13 at 3:00 p.m. she verified R17's care plan identified she wore upper and lower dentures and verified the care plan had not been revised to reflect the current interventions for R17, indicating she no longer wore the dentures and that only upper dentures were

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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 280	Continued From page 11 available. The DON stated the care plan should have been revised to reflect R17's current dental status.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care as written for 1 of 1 resident (R20) whose plan of care required interventions related to behavioral issues; and for 1 of 3 residents (R19) reviewed who required assistance with dental hygiene. Findings include: R19 had a quarterly Minimum Data Set (MDS) dated 10/8/13 which indicated R19 required extensive assist of 1 staff with eating and grooming needs. The care plan indicated staff was required to assist with oral cares by brushing dentures and placing them into R19's mouth. It was observed that R19 was not wearing dentures during the following times: on 12/10/13 at 9:30 a.m., on 12/11/13 at 9:45 a.m. during the breakfast meal and on 12/11/13 at 12:00 p.m. during the noon meal. On 12/11/13 at 9:25 a.m., nursing assistant (NA)-A and NA-B assisted R19 with all morning cares. Upon completion of oral cares, they failed to place dentures into R19's	F 282	**F 282** R20 & R19's care sheets were reviewed with care plan updates to reflect current needs. All resident care sheets have been audited with NA/R input to assure complete ADL needs are addressed and correspond to the plan of care. Licensed staff will complete observational audits of staff performance to assure all cares are provided as needed. All staff providing cares will be educated on the importance of providing outlined care by 1/20/14. These audits will be completed q shift X 7 days. Additional, random audits will be completed at least weekly X 30 days. The DON or designee will compile audit data & present to the QAA Committee for review and/or comment.	1/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245547	A. BUILDING _____ B. WING _____	12/12/2013

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F 282	Continued From page 12 mouth. NA-A commented on 12/11/13 at 10:00 a.m. that R19 never wears dentures anymore. On 12/11/13 at 12:00 p.m. the director of nursing (DON) stated that she thought R19 had been wearing dentures during meal time but then the dentures would be removed after the completion of the meal. The DON indicated she had been unaware that the dentures had not been placed into R19's mouth and further verified the plan of care had not been followed as written. R20 had diagnoses which included: Alzheimer's disease, depression, anxiety, and psychosis. A quarterly Minimum Data Set (MDS) assessment dated 10/30/13, indicated R20 had impaired memory with severely impaired decision making. In addition, the MDS also indicated R20 required extensive assistance with activities of daily living, and exhibited behavioral symptoms 1-3 days/week. The care plan dated 6/23/13 and titled " behaviors " addressed that R20 had socially inappropriate and disruptive behaviors and the goal identified for this behavior included "loud and yelling noises will occur less than 2 times per day". Interventions included: provide activities for resident one on one basis, avoid over stimulation, administer medication, maintain a calm environment and approach the resident. The plan also indicated that when R20 became socially inappropriate, staff were to provide comfort measures for basic needs. During an observation of R20 at 5:10 p.m. on 12/9/13, R20 was yelling out in the dining room. At 5:12 p.m. staff brought R20 her supper meal, R20 took a few bites of food and pushed the plate away. At 5:15 p.m. R20 continued to yell out in	F 282		

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F 282	Continued From page 13 the dining room without any staff intervention. Two tablemate's kept staring at R20 during this time. At 5:20 p.m. a nursing assistant (NA)-A sat down to assist the resident with eating. At 5:41 p.m. the NA-A asked the resident "Are you done? " It was noted that staff never addressed the continued yelling nor inquired if R20 was in need of anything. During an observation on 12/11/13 at 9:00 a.m., R20 was heard to intermittently yell out while she was seated at a table in the dining room. During continued observations, R20 was noted to continue to yell out until 10:00 a.m. when staff transported R20 back to her room. Staff were not observed to attempt any behavioral interventions during the time R20 was yelling out. During lunch observations on 12/11/13 from 11:30 a.m. until 12:10 p.m., R20 yelled out as she ate in the dining room with staff assistance. On 12/12/13 at 9:15 a.m., R20 was observed yelling out and staff did not address the behavior nor implement any individualized interventions. On 12/12/13 at 9:00 a.m. during an interview with the director of nursing (DON), she verified that R20 does yell out intermittently. It was also verified the care plan had not been followed as written related to interventions identified for resident behaviors.	F 282		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives	F 318	**F 318** R19's care sheets were reviewed with care plan updates to reflect current needs.	

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F 318	Continued From page 14 appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide the necessary services to maintain range of motion (ROM) for 1 of 1 resident (R19) reviewed who had limited range of motion. Findings include: R19 was admitted with diagnoses that included: Parkinson's disease, tremors and chronic pain. During an observation on 12/9/13, R19 was observed to have a contracted right hand and was unable to fully open her hand. There were no splints or braces evident. R19's annual care area assessment (CAA) dated 4/7/2013 failed to identify R19 with any limitation with ROM. The most recent quarterly Minimum Data Set (MDS) dated 10/8/2013 showed no impairment in upper or lower extremity function. A comprehensive assessment related to the limited range of motion in the right hand and wrist was not evident so a program could be implemented to maintain and/or improve function. On 12/10/13 at 2:00 p.m., an interview with licensed practical nurse (LPN)-A verified that R19 had a contracture in her right hand and wrist. Nursing assistant (NA)-C was present at the time of the interview and stated R19 did not receive any ROM during cares.	F 318	All resident care sheets have been audited with NA/R input to assure complete ADL needs are addressed and correspond to the plan of care. Licensed staff will complete observational audits of staff performance to assure all cares are provided as needed. All staff providing cares will be educated on the importance of providing outlined care by 1/20/14. These audits will be completed q shift X 7 days. Additional, random audits will be completed at least weekly X 30 days. The DON or designee will compile audit data & present to the QAA Committee for review and/or comment.	1/20/14

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F 318	Continued From page 15	F 318		

On 12/10/2013 at 2:55 p.m., the physical therapy assistant (PTA) was interviewed and verified R19's right hand was contracted and that therapy and exercises would be beneficial.

On 12/10/13 at 3:00 p.m., the director of nursing (DON) verified that R19 had a contracted right hand and wrist that should be evaluated. The DON stated that the trained medication assistant (TMA) provided restorative therapy 3 times a week but did not perform any restorative exercises with R19 and further indicated the noted ROM had not changed since admission.

It was observed on 12/11/13 at 9:00 a.m. that NA-A and NA-B provided total assistance with all activities of daily living, including bathing, dressing, grooming and oral cares without the participation of R19. On 12/11/13 at 9:30 a.m. R19 was observed in the dining room for breakfast and was observed to be totally fed by NA-D. NA-D stated R19 sometimes would attempt to feed herself but it was difficult.

On 12/11/13 at 12:30 p.m., the TMA verified that restorative therapy was provided after a physician order is received and indicated that R19 had not been a part of the restorative program.

During an interview on 12/11/13 at 12:00 p.m. with the DON, it was confirmed that a plan had not been developed which included any restorative or maintenance program for R19. The DON indicated that an assessment of the identified limited range of motion had not occurred and therefore no range of motion implemented. The right hand and wrist contracture had not been identified so that the

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F 318	Continued From page 16 appropriate interventions could be implemented to maintain and/or prevent further limited range of motion.	F 318		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441	**F 441** NA-A & NA-B were re-educated on what time frames constitute glove changes. All staff were re-educated on the proper protocols for glove usage by 1/20/14. Observational f/u audits were conducted with NA-A & NA-B by the DON to assure compliance. The DON or designee[s] will conduct other observational audits of personal cares and glove protocols by nursing staff per observational audits as outlined in F282. Other random audits of glove usage will be performed daily during walking rounds by the Administrator. Audit outcomes will be presented to the QAA Committee for review & comment.	1/20/14

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F 441	Continued From page 17 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure that staff properly changed gloves during personal cares to maintain good infection control practices for 2 of 6 residents (R17 & R19) who were observed during personal cares. Findings include: During an observation on 12/11/13 at 9:00 a.m., nursing assistant (NA)-A and NA-B performed morning cares for R19. NA-A assisted R19 into the bathroom and provided perineal care with gloved hands. Without a change of gloves, NA-A pulled up R19's pants. NA-A then removed her gloves and washed her hands. Staff failed to change gloves after contamination and prior to handling clean clothing/items. During a subsequent observation on 12/11/13 at 9:26 a.m., NA-A and NA-B completed morning cares for R17. NA-A and NA-B washed and dressed R17 while wearing gloves. NA-A and NA-B then assisted R17 to stand up and proceeded to pull up her pants. Both NA-A and NA-B assisted R17 into the bathroom, removed her wet/soiled brief, tossed it into the garbage and then proceeded to remove their gloves. After new gloves were donned, they completed perineal care and pulled up her pants. Without removal of the soiled gloves, they walked R17 to the wheelchair and assisted her to sit down. After	F 441		

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F 441	Continued From page 18 the R17 was seated, NA-A and NA-B removed their soiled gloves and washed their hands. NA-A and NA-B were observed to complete perineal cares and handle clean items without removing gloves or washing their hands During interview with NA-B on 12/11/13 at 12:50 p.m., NA-B stated she was taught to change gloves when going from "dirty to clean." NA-B indicated she had not been instructed on specific intervals of when to change gloves. During interview with the director of nursing (DON) on 12/11/13 at 2:25 p.m., she stated the expectation was to change gloves after completion of perineal cares and before handling clean items [clothing] due to cross contamination. The DON stated staff were updated annually in proper infection control standards. The facility handwashing policy 2.2.6 and 2.2.7 indicated that hands will be washed before touching clean items and after handling contaminated items; policy 2.3 identified the use of gloves does not eliminate the need for handwashing; and hands will be washed immediately upon or as soon as feasible upon removal of gloves or other personal protective equipment.	F 441		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465	**F 465** The dish room walls & floor have been scrubbed. A cleaning schedule for the walls, floors and other areas/utensils in the kitchen has been established.	

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F 465	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility did not ensure the floors and walls in the dishwashing room were properly cleaned where dishes and utensils are cleaned for 24 residents who reside in the facility. Findings include: On 12/9/13 at 2:25 p.m. an initial kitchen tour was conducted with the dietary director (DD). The dishwashing room was observed to have a build up of black grime on the flooring and the wall. The DD verified the flooring and wall were very dirty. She stated that dietary staff clean the kitchen floor daily and the maintenance/housekeeping staff use a scrubbing machine once a week. The DD could not give a specific date the flooring and the wall had last been cleaned in the dishwashing room. On 12/12/13 at 8:30 a.m., an environmental tour was conducted with the maintenance director. The maintenance director stated he was unaware that the walls and floor in the dishwashing room were dirty. Although requested at that time, neither a policy nor a cleaning log were provided to indicate these areas had been part of any routine maintenance.	F 465	The Administrator with the DD will conduct a daily walk-through the dietary area to assure compliance X14 days. Weekly, the Administrator will review with the DD, the comprehensive cleaning schedule to assure compliance. Sanitation audits will be presented to the QAA Committee for review &/or comment.	1/20/14

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K 000	INITIAL COMMENTS	K 000		

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.

Dc: 1-21-14

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.

Pocok
PB 1-24-14

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on December 11, 2013. At the time of this survey, Building 01 of Adrian 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) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

Exit: 12-12-13

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

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

RECEIVED
JAN 22 2014
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Scott Kowalke	Administrator	1/15/14

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

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

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K 000	Continued From page 2 construction from the 2009 addition of Type I(332) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 30 beds and had a census of 24 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based upon a staff interview and review of available records, the facility was unable to document the minimum 30% loading of the emergency generator, during monthly load tests conducted in the previous year. This deficient practice was not in conformance with the requirements at NFPA 101 (2000) Chapter 9, Section 9.1.3. In a fire or other emergency, this deficient practice could adversely affect 30 of 30 residents, staff and visitors.	K 144	**K 144** Cummins Central Power, LLC will be at the facility on 1-17-14 to perform a 2 hour load bank to meet the NFPA regulation. Documentation of this test will be placed in the Fire Safety Generator PM book. Maintenance Supervisor will monitor for annual testing.	

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K 144	Continued From page 3 FINDINGS INCLUDE: On 12/11/2013 at 8:50 AM, during a review of the facility's monthly test logs for the emergency generator (genset), it was confirmed the genset was not exercised at not less than 30% of the EPS nameplate rating during every month of the previous year. Further, no documentation could be provided verifying the genset had been exercised using supplemental loads, i.e., load-banked, within the previous year. This deficient practice was not in conformance with the requirements at NFPA 110 (99) Sections 6-4.2 and 6-4.2.2. This finding was confirmed with the facility administrator.	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245547	A. BUILDING **02 - 2009 LINK TO ASSISTED LIVING** B. WING _____	**12/11/2013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on December 11, 2013. At the time of this survey, Building 02 of Adrian 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) 101 Life Safety Code (LSC), Chapter 18 New Health Care Occupancies.

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

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Scott Kessler	Administrator	1/15/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245547	A. BUILDING **02 - 2009 LINK TO ASSISTED LIVING** B. WING _____	**12/11/2013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		

By eMail to:
Marian.Whitney@state.mn.us

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

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Adrian Care Center was constructed as follows:
Building 01 - The original building was constructed in 1969, is one-story in height, has a partial basement, is fully fire sprinkler protected and is of Type II(000) construction;
A building addition was constructed in 1976, it is one-story in height, has no basement, is fully fire sprinkler protected and is of Type II(000) construction.
Building 02 - Consists of a link to an assisted living facility. It was built in 2009, is one-story in height, has no basement, is fully fire sprinkler protected and is of Type I(332) construction. There are no patient sleeping or treatment areas in Building 02.

A two-hour fire wall separates the Nursing Home from an attached clinic, and the single communicating opening is protected by a labeled, self-closing, 90-minute fire-rated door assembly. Also, a two-hour fire wall with a labeled, self-closing, 90-minute fire-rated door assembly separates the 1969 building of Type II(000)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245547	A. BUILDING **02 - 2009 LINK TO ASSISTED LIVING** B. WING _____	**12/11/2013**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 construction from the 2009 addition of Type I(332) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 30 beds and had a census of 24 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based upon a staff interview and review of available records, the facility was unable to document the minimum 30% loading of the emergency generator, during monthly load tests conducted in the previous year. This deficient practice was not in conformance with the requirements at NFPA 101 (2000) Chapter 9, Section 9.1.3. In a fire or other emergency, this deficient practice could adversely affect 30 of 30 residents, staff and visitors. FINDINGS INCLUDE:	K 144	**K 144** Cummins Central Power, LLC will be at the facility on 1-17-14 to perform a 2 hour load bank to meet the NFPA regulation. Documentation of this test will be placed in the Fire Safety Generator PM book. Maintenance Supervisor will monitor for annual testing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245547	A. BUILDING **02 - 2009 LINK TO ASSISTED LIVING** B. WING _____	**12/11/2013**

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

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K 144	Continued From page 3 On 12/11/2013 at 8:50 AM, during a review of the facility's monthly test logs for the emergency generator (genset), it was confirmed the genset was not exercised at not less than 30% of the EPS nameplate rating during every month of the previous year. Further, no documentation could be provided verifying the genset had been exercised using supplemental loads, i.e., load-banked, within the previous year. This deficient practice was not in conformance with the requirements at NFPA 110 (99) Sections 6-4.2 and 6-4.2.2. This finding was confirmed with the facility administrator.	K 144		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7246

December 30, 2013

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5547023

Dear Ms. Baker:

The above facility was surveyed on December 9, 2013 through December 12, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to:

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 East Lyon Street
Marshall, MN 56258-2529

Office: (507) 537-7158
Fax: (507) 537-7194

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00405	A. BUILDING: _____ B. WING _____	12/12/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On December 9, 10, 11 and 12th, 2013, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 1/15/14