DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	ICARE/MEDICAID CERTIFICATION A 'I - TO BE COMPLETED BY THE STAT		ID: 51X6 Facility ID: 00313
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245410 2.STATE VENDOR OR MEDICAID NO. (L2) 585219600	3. NAME AND ADDRESS OF FACILITY (L3) RICE CARE CENTER (L4) 1801 SOUTHWEST WILLMAR AVENU (L5) WILLMAR, MN		4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	5. vanuation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 12/11/2015 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/III 04 SNF 08 OPT/SP 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 78 (L18) 13. Total Certified Beds 78 (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 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A*	Following Requirements: 6. Scope of Services Limit 7. Medical Director 8. Patient Room Size 9. Beds/Room (L12)
14. LIC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 78	ICF IID	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38) (L39)	(L42) (L43)		
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE S 17. SURVEYOR SIGNATURE Brenda Fischer, Unit Supervis PART II - TO	Date :	18. STATE SURVEY AGENCY APP <u>Kate JohnsTon, Pro</u> LOFFICE OR SINGLE STATI	ogram Specialist 01/08/2015 (L20)
 19. DETERMINATION OF ELIGIBILITY _X_ 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21) 	20. COMPLIANCE WITH CIVIL RIGHTS ACT:		ıl Solvency (HCFA-2572) Iterest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE 23. LTC AGREEM OF PARTICIPATION BEGINNING 01/01/1987		26. TERMINATION ACTION: <u>VOLUNTARY</u> 00 01-Merger, Closure	05-Fail to Meet Health/Safety
(L24) (L41) 25. LTC EXTENSION DATE: 27. ALTERNATIVE A. Suspension of (L27) B. Rescind Sus	of Admissions: (L44)	02-Dissatisfaction W/ Reimbursemen 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	t 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change 00-Active
	(L45)		
28. TERMINATION DATE: 29	. INTERMEDIARY/CARRIER NO.	30. REMARKS	
	03001		
(L28)	(L31)	-	
31. RO RECEIPT OF CMS-1539 32	DETERMINATION OF APPROVAL DATE	Posted 01/26/2016 Co.	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245410 January 8, 2016

Ms. Pam Adam, Administrator Rice Care Center 1801 Southwest Willmar Avenue Willmar, Minnesota 56201

Dear Ms. Adam:

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 November 24, 2015 the above facility is certified for or recommended for:

78 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 78 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.

Rice Care Center January 8, 2016 Page 2

Sincerely,

ate Comston X

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



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered January 8, 2016

Ms. Pam Adam, Administrator Rice Care Center 1801 Southwest Willmar Avenue Willmar, Minnesota 56201

RE: Project Number S5410025

Dear Ms. Adam:

On November 18, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 29, 2015. 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 December 11, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 1, 2015 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 October 29, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 24, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 29, 2015, effective November 24, 2015 and therefore remedies outlined in our letter to you dated November 18, 2015, 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,

Tomston

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

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 245410	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 12/11/2015
Name	of Facility		Street Address, City, State, Zip Code	
RI	CE CARE CENTER		1801 SOUTHWEST WILLMAR AVE WILLMAR, MN 56201	NUE

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	(Y!	5)	Date	(Y4)	ltem		Y5) [Date
			Correction				(Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0176		11/18/2015		ID Prefix	F0225	_	11/23/2015		ID Prefix	F0226		_11/24/2015
0	483.10(n)				-	483.13(c)(1)(ii)-(iii), (c)(2)	- (4)		-	483.13(c)		_
LSC					LSC		_			LSC			-
			Correction					Correction					Correction
ID Prefix	F0282		Completed 11/19/2015		ID Prefix	F0314		Completed 11/19/2015		ID Prefix	F0315		Completed 11/23/2015
Rea #	483.20(k)(3)(ii)				Rea #	483.25(c)				Rea #	483.25(d)		_
							_			0			-
			Correction				(Correction					Correction
			Completed				(Completed					Completed
ID Prefix					ID Prefix					ID Prefix			_
Reg. #					Reg. #					Reg. #			-
LSC					LSC		_			LSC			-
			Correction				,	Correction					Correction
			Completed					Completed					Completed
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			_
Reg. #					Reg. #					Reg. #			
LSC					LSC		_			LSC			-
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix		1	Completed		ID Prefix			Completed
Reg. # LSC					Reg. # LSC					Reg. # LSC			-
							_						-
Reviewed By	Revie	wed E	3y	Da	te:	Signature of Sur	vey	vor:				Date:	
State Agency	,	BF	/KJ	01	/08/201	.6		1056	2			12/	11/2015
Reviewed By	Revie	wed E	By	Da	te:	Signature of Sur	/ey	vor:				Date:	
CMS RO													
Followup to	Survey Completed on	:				Check for an	ıγι	Jncorrected D	eficie	ncies. Was	a Summary of		
	10/29/2015	5				Uncorrec	ted	Deficiencies	(CMS	-2567) Sent	to the Facility?	YES	NO

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 245410	(Y2) Multiple Constr A. Building B. Wing	ADDITION	(Y3) Date of Revisit 12/1/2015
Name	of Facility		Street Address, City, State, Zip Code	
RI	CE CARE CENTER		1801 SOUTHWEST WILLMAR AVE WILLMAR, MN 56201	NUE

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)	ltem		(Y5)	Date
			Correction				Correction					Correction
ID Drofiv			Completed 10/29/2015		ID Drofiv		Completed		ID Drofiv			Completed
			10/29/2015				-					
-	NFPA 101 K0147				Reg. #		-		Reg. #			
	10147			<u> </u>					200			
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix					ID Prefix		-		ID Prefix			
Reg. #					Reg. #				Reg. #			
LSC					LSC				LSC			
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix					ID Prefix		-		ID Prefix			
Reg. #					Reg. #				Reg. #			
LSC					LSC		-		LSC			
			Compation				Correction					Comostion
			Correction Completed				Correction Completed					Correction Completed
ID Prefix			Completed		ID Prefix		_		ID Prefix			
Reg. #					Reg. #				Reg. #			
LSC					LSC		-		LSC			
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix			completed		ID Prefix		-		ID Prefix			
Reg. #					Reg. #				Reg. #			
LSC					LSC		-		LSC			
Reviewed By	y Re	eviewed B	у У	Da	te:	Signature of Surve	yor:	1			Date:	
State Agenc	у	K	S/KJ	01	/08/2016		34764	1			12	2/01/2015
Reviewed By	y Re	eviewed B	έy.	Dat	te:	Signature of Surve	yor:				Date:	
CMS RO												
Followup to	Survey Complete	d on:				Check for any				•		
	10/27/2	015				Uncorrecte	d Deficiencie	s (CMS	6-2567) Sent t	o the Facility?	YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					ND TRANSMITTAL		51X6
1. MEDICARE/MEDICAID PROVIDER		3. NAME AND ADI			E SURVEY AGENCY	4. TYPE OF ACTION:	2 (L8)
(L1) 245410	NO.	(L3) RICE CARE		11			2 (Lo) 2. Recertification
2.STATE VENDOR OR MEDICAID NO		(L4) 1801 SOUTH	WEST WILLMA	AR AVENU	Έ	1. Initial 3. Termination	 Recertification CHOW
(L2) 585219600		(L5) WILLMAR,	MN		(L6) 56201	5. Validation 7. On-Site Visit	6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF OW (L9)	VNERSHIP	7. PROVIDER/SUP 01 Hospital	PPLIER CATEGORY 05 HHA	Y 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Con	
6. DATE OF SURVEY 10/2	9/2015 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		C 475
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING I	DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:				
From (a):		X A. In Complian	ce With		And/Or Approved Waivers Of The	e Following Requirements:	
To (b) :		Program Re Compliance			2. Technical Personnel	6. Scope of Servic	
12. Total Facility Beds	78 (L18)		cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SNF)	7. Medical Directo 8. Patient Room Si	
					5. Life Safety Code	9. Beds/Room	
13.Total Certified Beds	78 (L17)		pliance with Program ents and/or Applied V		* Code: A1*	(L12)	
14. LTC CERTIFIED BED BREAKDOW	Ň				15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
78							
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICABLE S		ATION DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AP	PROVAL	Date:
Bruce Melcher	t, HFE NE II		11/18/2015	(L19)	Kate JohnsTon, Pr	ogram Specialist	12/03/2015 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RH	EGIONAI	COFFICE OR SINGLE STAT	TE AGENCY	
19. DETERMINATION OF ELIGIBILIT	Y		PLIANCE WITH C	IVIL	21. 1. Statement of Financi		
1. Facility is Eligible to Pa	articipate	RIGH	ITS ACT:		 Ownership/Control I Both of the Above : 	Interest Disclosure Stmt (HCFA	-1513)
2. Facility is not Eligible							
	(L21)						
22. ORIGINAL DATE	23. LTC AGREEMI	ENT 2	4. LTC AGREEME	ENT	26. TERMINATION ACTION:	(L	30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DATE	E	<u>VOLUNTARY</u> 00	INVOLUNTA	ARY
01/01/1987					01-Merger, Closure		et Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursemen	nt 06-Fail to Me	et Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVI	E SANCTIONS			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER	
	A. Suspension of	of Admissions:	(L44)		04-other Reason for withdrawar	07-Provider S 00-Active	Status Change
(L27)	B. Rescind Sus	pension Date:	(L44)			00110010	
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION C	OF APPROVAL DAT	ГЕ	Posted 12/04/2015 Co.		
	(L32)			(L33)	DETERMINATION APPRO	VAL	



Electronically delivered November 18, 2015

Ms. Pam Adam, Administrator Rice Care Center 1801 Southwest Willmar Avenue Willmar, Minnesota 56201

RE: Project Number S5410025

Dear Ms. Adam:

On October 29, 2015, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), 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>Electronic 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

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

Protecting, Maintaining and Improving the Health of Minnesotans Minnesota Department of Health • Health Regulation Division General Information: 651-201-5000 • Toll-free: 888-345-0823 http://www.health.state.mn.us An equal opportunity employer Rice Care Center November 18, 2015 Page 2

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:

Brenda Fischer, Unit Supervisor Minnesota Department of Health Health Regulation Division 3333 West Division, #212 St. Cloud, Minnesota 56301 Telephone: (320)223-7338 Fax: (320)223-7348

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 December 8, 2015, 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.

Rice Care Center November 18, 2015 Page 4

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 January 29, 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 April 29, 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:

Rice Care Center November 18, 2015 Page 5

> 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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, Interim Supervisor Health Care Fire Inspections State Fire Marshal Division Email: <u>tom.linhoff@state.mn.us</u> Telephone: (651) 201-7205 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

ate Johnston

Kate JohnsTon, Program Specialist Licensing and Certification Program Health Regulation Division kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

		AND HUMAN SERVICES		FORM	APPROVED
		& MEDICAID SERVICES			. 0938-0391
-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E SURVEY IPLETED
		245410	B. WING _	10	/29/2015
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
RICE CA	RE CENTER			1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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 COMMENT	S	F 00	0	
	as your allegation o Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve f compliance upon the btance. Because you are our signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance.			
F 176 SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ar facility may be conducted to ntial compliance with the an attained in accordance with NT SELF-ADMINISTER D SAFE	F 17	6	11/18/15
	the interdisciplinary	nt may self-administer drugs if team, as defined by is determined that this			
	by: Based on observat review, the facility fa residents (R11), wit medication order, e medications after se Findings include: R11' physician orde the diagnoses of A delusions and disru minimum data set (JT is not met as evidenced ion, interview and document ailed to ensure that 1 of 1 h a self-administration of entirely consumed the et up. r report, dated 9/16/15, listed zheimer's dementia with ptive behaviors. The Annual MDS), dated 8/11/15 indicated xtensive assistance with most		Corrective Action: Resident 11 self-administration of medications assessment completed for meds mixed in coffee/liquids after set up by nursing staff. Telephone order obtained from physician. Corrective Action-identify other residents: All residents that self-administer medications after set up have been identified to assure self-administration of	
		ER/SUPPLIER REPRESENTATIVE'S SIGN		TITLE	(X6) DATE

Electronically Signed

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.

11/28/2015

PRINTED: 12/04/2015

	RS FOR MEDICARE	& MEDICAID SERVICES	(X2) MULT	IPLF		<u>MB NO.</u>	APPROVEI 0938-039 survey
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245410	B. WING _			10/2	29/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RICE CA	RE CENTER				801 SOUTHWEST WILLMAR AVENUE /ILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIOI DATE
F 176	cognitively impaired In review of the mo orders, dated 9/16/ Seroquel (anti-psyc milligrams (mg) eve mix in coffee. During observation R11 was sitting at a Cushman Cottage.	ing, and also was severely,	F 17	76	medication assessment is complet physician orders are in place. Corrective action to prevent reoccu Self-administration of medication p and procedure reviewed at Nurses meeting 11/19/2015. Education re- the need to go back and check on residents to assure their medicatio been taken per policy. Monitoring for Compliance:	urrence: olicy /TMA garding the	
	glass of water, one cup of coffee). In an licensed practical n placed R11's Seroc 6:01 p.m., R11 plac pushed her way fro herself to the dayro "Wheel of Fortune." approximately 1/2 R11's cup. Two oth	glass of orange juice and one n interview at 5:52 p.m., jurse (LPN)-A stated she quel in her orange juice. At ced her napkin on her table, im her table and wheeled bom down the hall to watch			DON or designee will audit residen are self-administering medications set up are taken completely per po Audits will be completed twice a we one month then weekly for one mo various shifts. The results of these will be discussed and reviewed at 0 will determine when compliance is indicated.	after licy. eek for nth on audits	
	when the surveyor orange juice left in unaware that R11 h juice, which contain and after grabbing	A returned to the dining room, asked about the medicated the cup by R11. LPN-A was had not finished the orange hed the Seroquel medication, the glass, took it to the 1 sat watching TV and had er medication.					
	Alzheimer's, with se paranoia, auditory h and long term mem	icated that R11 had evere dementia with behaviors, hallucinations, and both short hory loss. The care plan further proach, that R11 needed					

If continuation sheet Page 2 of 18

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	12/04/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245410	B. WING		10/:	29/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
RICE CA	RE CENTER			1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 176 F 225 SS=D	poor vision, and her The approach direct (powder laxative) ar coffee so that she v During interview on registered nurse (R Seroquel for maintai in her environment, behaviors associate hallucinations. RN-/ medications in the r prior auditory halluc felt the single dose beneficial for R11 in need to make sure, in food and/or beve consumed totally. A self administration for R11 was requess indicated none had A facility Policy entit Medication, last rev provision for resider impaired, and how the monitored for comp placed in their food 483.13(c)(1)(ii)-(iii), INVESTIGATE/REF ALLEGATIONS/INE The facility must no been found guilty of mistreating resident	dication administration due to refusal to take [medication]. ted that both R11's Miralax nd Seroquel be mixed in yould take it. 10/29/2015 9:15 a.m., N)-A stated R11 needed ining her ability to be involved and also due to R11's ed with paranoia and auditory A stated that R11 will only take morning due to one of her inations, and R11's physician of Seroquel was more the evening. RN-A said staff that when mixing medications rages, that medications were n of medication assessment ted from the facility, but RN-A been completed. ded Self Administration of ised 12/06, did not include nts, who were cognitively they would be assessed and liance, when medications are and fluids. (c)(2) - (4) PORT	F 176			11/23/15

Facility ID: 00313

If continuation sheet Page 3 of 18

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/04/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245410	B. WING			10/2	29/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RICE CA	RE CENTER				801 SOUTHWEST WILLMAR AVENUE VILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	registry concerning of residents or misa and report any know court of law against indicate unfitness for other facility staff to or licensing authorit The facility must en involving mistreatm including injuries of misappropriation of immediately to the a to other officials in a through established State survey and ce The facility must ha violations are thoroup prevent further pote investigation is in pu The results of all inv to the administrator representative and with State law (inclu- certification agency incident, and if the a appropriate correcti This REQUIREMEN by: Based on interview facility failed to repo	abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a an employee, which would or service as a nurse aide or the State nurse aide registry ies. sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law accordance with State law accordance that all alleged ughly investigated, and must ential abuse while the rogress. vestigations must be reported or his designated to other officials in accordance uding to the State survey and) within 5 working days of the alleged violation is verified ve action must be taken. NT is not met as evidenced w and document review, the ort allegations of abuse state agency for 1 of 3	F2	225	Corrective Action: A Vulnerable Adult report was filed v MDH/OHFC on 10/29/2015 for resid Investigation followed report to		

Facility ID: 00313

If continuation sheet Page 4 of 18

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/04/2015 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		E SURVEY PLETED
		245410	B. WING _			10/2	29/2015
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
RICE CA	RE CENTER				01 SOUTHWEST WILLMAR AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	Continued From pa Findings include:	-	F 22		MDH/OHFC.		
	9/29/15, indicated a required assist of or daily living. R3's can identified R3 as a "v did not address are interventions to pro- During an interview R3 reported two sta abused her. When "ummm, some of th with,they treat me of when handling me." (aide) on the day sh shift. R3 stated she about one of them, further stated the tre had not improved, a report the other state	num Data Set, MDS dated she was cognitively intact and ne to two staff for activities of re plan dated 9/29/15 vulnerable adult," however, it as of vulnerability, nor any tect R3 from abuse. on 10/27/15, at 12:56 p.m., off members in the facility had asked which staff, R3 replied, he aides I've had problems juite rudely, and are rough ' R3 stated there was one hift, and one on the evening e spoke to the nurse manager and "the girl denied it." R3 eatment by that staff member and so R3 stated she "did not ff member" due to lack of complaint. R3 further also I would call that abuse when o me."			Corrective Action to Prevent reoccurrence: The Vulnerable Adult Abuse Preven Policy and Procedure has been rev read: When a report of suspected a or neglect of a vulnerable adult is received, the abuse or neglect will b reported on the MDH system. Follo this report, the VA committee will in an investigation. Corrective action to prevent reoccu Education to staff was completed o November 19, 2015. Education inc when a report of suspected abuse of neglect of a vulnerable adult is receive the abuse or neglect will be reported the MDH system. Following this rep the VA committee will initiate an investigation.	ised to abuse pe pwing itiate rrence: n luded, pr sived, d on	
	the facility administr Review of R3's Pro- indicated, "It was br that resident had a member abusing he [director of nursing] this concern. Resid concerns. When as when [staff] provide talked to you about	ted R3's allegation of abuse to rator on 10/27/15, at 3:19 p.m. gress Note dated 10/27/15 rought to this writer's attention concern regarding a staff er. This writer and DON visited with resident regarding ent initially denied any ked again, she stated, 'It is s my cares.' [R3] stated that, 'I her before, but you did not do 'his writer reminded resident			Monitoring for Compliance: Current Policy and Procedure state following report of Vulnerable Adult and Neglect, immediately notify the and Administrator. Since the DON Administrator are notified immediate following the VA report, we can ens report was filed immediately. Memil the Vulnerable Adult Committee (Administrator, DON, or Social Servi will audit Vulnerable Adult reporting	Abuse DON and ely ure the bers of <i>v</i> ices)	

Facility ID: 00313

If continuation sheet Page 5 of 18

		& MEDICAID SERVICES				APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		245410	B. WING _		10/2	29/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
RICE CA	RE CENTER			1801 SOUTHWEST WILLMAR A WILLMAR, MN 56201	AVENUE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 225	member] will not dia resident. Resident a this. Writer had pre- staff member] who uncomfortable disc resident. Resident f is rude to resident - resident much. She across the room an swings lift across th resident's bottom in the lift sheet under writer and DON hav for this staff member past. However, resi happened. Residen when the staff mem Suggested that this cares for resident. I is not necessary. R should not have sai explained to her tha safe and comfortab feel okay with the s During and intervier registered nurse (R my attention by the complaint." RN-A stat information about s with others inaccura	ly discussed that [the staff scuss her personal life with stated she felt offended by viously discussed this with [the	F 22	5 documentation for comp timeliness of reporting. designee will report con committee.	The DON or	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00313

If continuation sheet Page 6 of 18

		AND HUMAN SERVICES				FORM	12/04/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245410	B. WING			10/2	29/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RICE CA	RE CENTER				801 SOUTHWEST WILLMAR AVENUE VILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	and that two staff g because "This is wh During an interview stated that she was instances of abuse outside agencies bu questions regarding During an interview director of nursing (made by R3 were m agency. The DON room when RN-A sp never said she was [R3] didn't like the s stated, "I didn't feel Although, the facility of being mistreated immediately report Agency, but instead allegation. A facility policy, Vuli Prevention, Rice Ca indicated its purpos from mistreatment, seclusion and misa The policy directed suspected abuse to to the state agency.	erve cares with staff and R3 o into the room with R3 nat she does." on 10/28/15, at 8:46 a.m., R3 a ware of how to report both in the facility and to the ut declined any further g her previous allegations. on 10/29/15, at 8:46 a.m., the (DON) stated the allegations not reported to the state further stated she was in the poke with R3, and stated, R3 abused by the staff, only that staff member. The DON there was any abuse." y was aware of R3's allegation , the facility did not the incident to the State d began to investigate R3's nerable Adult Abuse are Center, dated 7/2015, se was "to protect residents neglect, abuse, involuntary ppropriation of their property." staff to immediately report any o the facility administrator and		225			11/24/15
F 226 SS=D	ABUSE/ŃEGLECT	, ETC POLICIES	F 2	226			11/24/15

CENTER		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	FOR OMB NO	D: 12/04/2015 M APPROVED D. 0938-0391 NTE SURVEY
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _	CC	OMPLETED
		245410	B. WING		1	0/29/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	
RICE CA	RE CENTER			-	301 SOUTHWEST WILLMAR AVENUE /ILLMAR, MN 56201	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226		ge 7 ect, and abuse of residents on of resident property.	F 2	226		
	by: Based on interview facility failed to ensu notified immediately	NT is not met as evidenced and document review the ure the stage agency was of an allegation of abuse as olicy for 1 of 3 resident d.			Corrective Action: A Vulnerable Adult report was filed with MDH/OHFC on 10/29/2015 for resident 3 Investigation followed report to MDH/OHFC.	J.
	indicated its purpos from mistreatment, seclusion and misa The policy directed suspected abuse to to the state agency. During an interview R3 told the surveyo facility had abused R3 replied, "Ummm problems with,they rough when handlin [aide] on the day sh shift. R3 stated she about one of them, R3 further stated th member had not im "did not report the c lack of result from t	are Center, dated 7/2015, e was "to protect residents neglect, abuse, involuntary opropriation of their property." staff to immediately report any the facility administrator and on 10/27/15, at 12:56 p.m., r, two staff members in the her. When asked which staff, , some of the aides I've had treat me quite rudely, and are g me." R3 said there was one ift, and one on the evening e spoke to the nurse manager and stated "the girl denied it." e treatment by that staff proved, and so R3 stated she ther staff member" due to he first one. R3 further also I would call that abuse when			Corrective Action to Prevent reoccurrence: The Vulnerable Adult Abuse Prevention Policy and Procedure has been revised t read: When a report of suspected abuse or neglect of a vulnerable adult is received, the abuse or neglect will be reported on the MDH system. Following this report, the VA committee will initiate an investigation. Corrective action to prevent reoccurrence Education to staff was completed on November 19, 2015. Education included when a report of suspected abuse or neglect of a vulnerable adult is received, the abuse or neglect will be reported on the MDH system. Following this report, the VA committee will initiate an investigation.)

Facility ID: 00313

If continuation sheet Page 8 of 18

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/04/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245410	B. WING _			10/2	29/2015
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
RICE CA	RE CENTER			-	01 SOUTHWEST WILLMAR AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	the facility administr During and interview registered nurse (R my attention by the complaint." RN-A s initially denied the a her about concerns During an interview director of nursing (made by R3 were n agency. The DON when RN-A spoke w said she was abuse didn't like the staff r didn't feel there was further stated, when reported, staff are resident first, then r file a report with the further stated, "If I w the building, we won investigate," and au feel I can get involv Although the facility of being mistreated immediately report Agency as directed	ted R3's allegation of abuse to rator on 10/27/15, at 3:19 p.m. w on 10/28/15, at 1:02 p.m., N)-A stated, "It was brought to administrator that R3 had a aid she spoke with R3, who occusations, but then spoke of with the staff member. on 10/29/15, at 8:46 a.m., the DON) stated the allegations ot reported to the state stated she was in the room with R3 and stated, R3 never ed by the staff, only that she nember. The DON stated, "I s any abuse." The DON n abuse is suspected or educated to protect the eport to the administrator and e state agency. The DON vould get a call when I'm not in uld report and then dded, "If I'm in the building, I ed and then make a decision."	F 2:	26	Monitoring for Compliance: Current Policy and Procedure states following report of Vulnerable Adult and Neglect, immediately notify the and Administrator. Since the DON Administrator are notified immediate following the VA report, we can ensi- report was filed immediately. Memil the Vulnerable Adult Committee (Administrator, DON, or Social Serv- will audit Vulnerable Adult reporting documentation for completeness are timeliness of reporting. The DON or designee will report compliance to to committee.	Abuse DON and ely ure the bers of <i>v</i> ices)	
F 282 SS=D	483.20(k)(3)(ii) SEF PERSONS/PER CA	VICES BY QUALIFIED	F 28	82			11/19/15

If continuation sheet Page 9 of 18

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245410 **B** WING 10/29/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1801 SOUTHWEST WILLMAR AVENUE RICE CARE CENTER** WILLMAR, MN 56201 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 282 Continued From page 9 F 282 must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced bv: Based on observation, interview and document F 282 Services By Qualified Person/s Per review, the facility failed to ensure staff followed Care Plan the plan of care for 1 of 3 residents, (R39) Corrective Action: identified at risk for pressure ulcers, who was not Staff has been educated for resident 39 if timely repositioned. In addition, the facility failed he is with family staff need to interrupt the to ensure staff followed the plan of care for 1 of 3 family time and reposition and check and residents (R39) reviewed who required change for urinary incontinence every 2 assistance with toileting. hour per care plan. Findings include: Correction Action-identify other residents: Care plans of dependent residents were reviewed for reposition time according to R39's admission minimum data set (MDS), dated tissue tolerance sitting & lying and 7/09/15, indicated R39 was moderately cognitively impaired, required extensive checking/ changing according to Bowel assistance with transferring and repositioning in and bladder assessments. . An bed and in wheelchair due to cerebral vascular individualized repositioning plan and accident (CVA) and was at risk for pressure ulcer toileting scheduled devised based on (PU) development and urinary incontinence. resident assessment. Corrective action to Prevent reoccurrence: The care area assessment for Pressure Ulcers, dated 7/10/15, indicated: "resident is at risk for Mandatory education to all nursing staff skin breakdown [related to] requiring extensive regarding the need to follow the resident assistance with bed mobility, he has [frequent] care plan for repositioning for residents incontinence of [bowel and bladder] and was identified at risk for skin break down and admitted to the facility with open areas [related to] toileting scheduled. Resident roster will moisture on coccyx [and] peri area (scrotum)." continue to identify the bottoms up heart The care area assessment for Urinary shape by resident name and how many Incontinence, dated 7/10/15, indicated: "resident hours between repositioning. has bladder [incontinence] [related to] [status post] [cerebral vascular accident]. He does not Monitoring for Compliance: feel the sensation most of passing his urine most DON or Designee will audit residents that of the time. [Occasionally he will state he needs need to be repositioned every two hours

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00313

If continuation sheet Page 10 of 18

PRINTED: 12/04/2015 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES		C		APPROVE 0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED		
		245410	B. WING _		10/2	29/2015		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
RICE CA	RE CENTER		1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE		
F 282	to void, and then wi accurate when he h currently two remai open area. Require [incontinence] and R39's care plan dat for skin breakdown incontinence, and w open areas under s R39's care plan fur be "turned [and] rep have heel protector during bathing/care R39's care plan fur incontinence of [bo [occasional] feeling not consistent since of his [bowel mover further indicated tha be checked and ch During observation R39 was observed the activity room ar the evening meal. If from 6:29 p.m. unti minutes) R39 rema 7:41 p.m., when R3 was returned to his family member visit when R39's family i R39's call light. At (NA)-A answered F retrieve more help 7:52 p.m. until 8:10 evening cares, whil	ill not. Rarely he will be has asked for urinal. He has ning open moisture [related to] is assist to manage his bed mobility." ted 7/2/15 identified "Is at risk [related to] immobility, vearing of a splint. [History] of scrotum, coccyx and heel." ther indicated that R39 was to position every two hours. Is to boots on at all times, expect is."	F 28	or less according to care plan. Au be done weekly for 4 weeks then t month for 1 month then monthly til Results will be brought to QA com for recommendation on the need t further audit.	wice a I stable. mittee			

If continuation sheet Page 11 of 18

		AND HUMAN SERVICES			FORM	: 12/04/2015 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245410	B. WING _		10/	29/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
RICE CA	RE CENTER			1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 282	lift, NA-A and NA-B p.m., once on his b NA-B removed a he brief, reveling a red inner buttocks fold. intact. NA-B perforr protective barrier cr brief. During in interview stated that it was no reddened in the are care. NA-B stated t checked/changed a placed in his wheel p.m. and 5:30 p.m. NA-A and NA-B sta repositioned and ch urinary incontinence During interview on director of nursing a stated that when the NA-B, R39 was place	placed R39 in bed. At 8:14 bed and on R39's left side, eavily saturated incontinent dened coccyx and bilateral R39's skin, however, was ned peri-care, applied a ream, and reapplied a new at 8:29 p.m., NA-A and NA-B bt uncommon for R39 to be ea noted during evening peri hat R39 was last and repositioned when he was chair for supper between 5:15 earlier this evening. Both ted R39 was to be necked and changed for	F 28	32		
	also indicated R39	was not checked/changed or R39's family was present.				
F 314 SS=D	repositioning and cl urinary incontinence not repositioned for 483.25(c) TREATM	by the facility to need hecked and changed for e every 2 hours, however was 2 hours and 45 minutes. ENT/SVCS TO RESSURE SORES	F 31	4		11/19/15
	resident, the facility	orehensive assessment of a must ensure that a resident lity without pressure sores				

Facility ID: 00313

If continuation sheet Page 12 of 18

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FORM OMB NO	12/04/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED
		245410	B. WING		10/	29/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	
RICE CA	RE CENTER				801 SOUTHWEST WILLMAR AVENUE /ILLMAR, MN 56201	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	does not develop prindividual's clinical of they were unavoida pressure sores recesservices to promote prevent new sores for by: Based on observat review, the facility fa (R39) with history of provided care to pre- pressure ulcers. Findings include: R39's admission mi 7/09/15, indicated F cognitively impaired assistance with tran- bed and in wheelch accident (CVA) and (PU) development. Pressure Ulcers, da indicated: "resident [related to] requiring bed mobility, he has [bowel and bladder] facility with open are coccyx [and] peri ar The facility's most r (dated 10/07/15) for continued to be at m breakdown. R39's T (Rice Care Center)	ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and a healing, prevent infection and from developing.	F3	314	F 314 Treatment/SVCS To Prevent/Heal Pressure Sores Corrective Action: Staff has been educated for resident 39 if he is with family staff need to interrupt the family time and reposition per care plan which also includes checking and changing. Corrective Action-identify other residents: Care plans of dependent residents were reviewed for reposition time according to tissue tolerance sitting & lying. An individualized repositioning plan devised based on resident assessment. Heart shape on resident roster that identifies residents that need repositioning every 2 hours or less. Corrective Action to prevent reoccurrence: Mandatory education to all nursing staff regarding repositioning for residents identified at risk for skin break down according to tissue tolerance. Resident roster will continue to identify the bottoms up heart shape by resident name and how many hours between repositioning	

Facility ID: 00313

If continuation sheet Page 13 of 18

STATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATI	0938-039 SURVEY PLETED
				à		
		245410	B. WING		10/2	29/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1801 SOUTHWEST WILLMAR AVENUE		
RICE CA	RE CENTER			WILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 314	of redness over bor assessment." R39's care plan dat for skin breakdown incontinence, and v open areas under s R39's care plan furt be "turned [and] rep have heel protector during bathing / car During observations R39 was observed the activity room an the evening meal. If from 6:29 p.m. until minutes) R39 rema 7:41 p.m., when R3 was returned to his family member visit when R39's family of R39's call light. At (NA)-A answered R retrieve more help f 7:52 p.m. until 8:10 evening cares, whill wheel chair. At 8:10 lift, NA-A and NA-B p.m., once on his b NA-B removed a he brief, reveling a red inner buttocks fold. intact. NA-B perform	ted 7/2/15 identified "Is at risk [related to] immobility, vearing of a splint. [History] of ccrotum, coccyx and heel." ther indicated that R39 was to position every two hours. Is to boots on at all times, expect	F 314	Monitoring for Compliance: DON or Designee will audit residuneed to be repositioned every two or less according to care plan. A be done weekly for 4 weeks then month for 1 month then monthly Results will be brought to QA cor for recommendation on the need further audit.	o hours udits will twice a till stable. nmittee	

						FORM	12/04/2015 APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245410	B. WING			10/2	29/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RICE CA	RE CENTER				801 SOUTHWEST WILLMAR AVENUE VILLMAR, MN 56201		
(X4) ID PREFIX TAG	ND PLAN OF CORRECTION IDENTIFICATION NUMBER IDENTIFICATION NUMBER IDENTIFICATION NUMBER RICE CARE CENTER INTAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION F 314 Continued From page 14 During in interview at 8:29 p.m., NA-A and N stated that it was not uncommon for R39 to reddened in the area noted during evening is care. NA-B stated that R39 was last reposit when he was placed in his wheel chair for sis between 5:15 p.m. and 5:30 p.m. earlier this evening. Both NA-A and NA-B stated R39 w be repositioned every 2 hours. During interview on 10/27/15 at 8:43 p.m., t director of nursing and CM-A, stated that withey had interviewed NA-A and NA-B had p R39 in his wheel chair before the evening is 5:25 p.m. and indicated they did not reposit resident while R39 was with family. R39 was assessed by the facility to need repositioning every 2 hours, however was in repositioned for 2 hours and 45 minutes. A policy regarding re-positioning of resident requested, but none provided. F 315 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 unles resident's clinical condition demonstrates th catheterization was necessary; and a reside who is incontinent of bladder receives approvent treatment and services to prevent urinar		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	During in interview stated that it was no reddened in the are care. NA-B stated t when he was place between 5:15 p.m. evening. Both NA-A be repositioned even During interview on director of nursing a they had interviewe R39 in his wheel ch 5:25 p.m. and indic resident while R39 R39 was assessed repositioning every repositioned for 2 h A policy regarding r requested, but none 483.25(d) NO CATH RESTORE BLADD Based on the reside assessment, the far resident's clinical co catheterization was who is incontinent of treatment and servit infections and to re- function as possible	at 8:29 p.m., NA-A and NA-B by uncommon for R39 to be a noted during evening peri hat R39 was last repositioned d in his wheel chair for supper and 5:30 p.m. earlier this A and NA-B stated R39 was to ery 2 hours. 10/27/15 at 8:43 p.m., the and CM-A, stated that when d NA-A and NA-B had placed hair before the evening meal at ated they did not reposition was with family. by the facility to need 2 hours, however was not ours and 45 minutes. e-positioning of residents was e provided. HETER, PREVENT UTI, ER ent's comprehensive cility must ensure that a s the facility without an is not catheterized unless the ondition demonstrates that necessary; and a resident of bladder receives appropriate ices to prevent urinary tract store as much normal bladder		314			11/23/15

If continuation sheet Page 15 of 18

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	OMB NO. (X3) DATI	E SURVEY	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	COM	PLETED	
		245410	B. WING _		10/2	29/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
RICE CA	RE CENTER			1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
F 315	Continued From pa	ge 15	F 3 [.]	15			
	review, the facility fa (R39) with urinary in according to the co Findings include: R39's admission m 7/09/15, indicated F cognitively impaired assistance with tran bed and in wheelch accident (CVA) and bladder. The care a Incontinence, dated indicated: "resident [related to] [status p accident]. He does passing his urine m he will state he nee Rarely he will be ac urinal. He has curre moisture [related to to manage his [inco The facility's policy, Incontinence (last ra all residents would and quarterly for ind facility identified a v an individualized pla The facility's most r TENA/SCA Bladder for R39 indicated "r Retraining Program	has bladder [incontinence] bost] [cerebral vascular not feel the sensation most of lost of the time. [Occasionally ds to void, and then will not. ccurate when he has asked for ently two remaining open] open area. Requires assist ontinence] and bed mobility." entitled: Bowel and Bladder eviewed 01/15), indicated that be assessed upon admission continence, and that after the roiding pattern would develop		F 315 No Cather, Prevent UTI, Bladder Corrective Action: Staff has been educated for resid he is with family staff need to inte family time and check and change reposition resident according to a Corrective Action-identify other m All residents with urinary incontin have been reviewed to insure ad assessments & care plans and interventions are in place to impor- maintain urinary incontinence. Corrective Action to Prevent reoccurrence: Education to all nursing staff was completed on November 19, 201 Education included the need for the care plan for all residents ind checking and changing &/or toile Monitoring for Compliance: DON or Designee will audit resid need to be checked and change repositioning according to care p Audits will be done weekly for 4 to then twice a month for 1 month to monthly till stable. Results will b to QA committee for recommend the need to further audit.	dent 39 if errupt the ge and care plan. esidents: ence curacy of rove or 5. following luding ting. ents that d with lan. weeks hen e brought		

If continuation sheet Page 16 of 18

		AND HUMAN SERVICES				FORM	12/04/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245410	B. WING			10/2	29/2015
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
RICE CA	RE CENTER				801 SOUTHWEST WILLMAR AVENUE NILLMAR, MN 56201		
(X4) ID PREFIX TAG	ID FIX G SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT 315 Continued From page 16 R39's care plan dated 7/2/15 identified "h incontinence of [bowel and bladder] - has [occasional] feeling of when he voids, but not consistent since CVA. He has no awa of his [bowel movements." R39's care pla further indicated that R39 was to be "resid be checked and changed with repositioni During observations on 10/27/2015 at 6:2 R39 was observed seated in his wheel ch the activity room and visiting with family fat the evening meal. During continuous obs from 6:29 p.m. until 7:41 p.m., (one hour minutes) R39 remained in the activity are 7:41 p.m., when R39, seated in the whee was returned to his room by family. R39 family member visited in the room until 7: when R39's family member left, and activ R39's call light. At 7:49 p.m. nursing assi (NA)-A answered R39's call light and wer retrieve more help for R39's evening care 7:52 p.m. until 8:10 p.m. NA-A and NA-B	Y MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	R39's care plan dat incontinence of [boy [occasional] feeling not consistent since of his [bowel mover further indicated that be checked and chat During observations R39 was observed the activity room and the evening meal. If from 6:29 p.m. until minutes) R39 rema 7:41 p.m., when R3 was returned to his family member visit when R39's family r R39's call light. At (NA)-A answered R retrieve more help f 7:52 p.m. until 8:10 evening cares, while wheel chair. At 8:10 lift, NA-A and NA-B p.m., once on his be NA-B removed a help brief, reveling a red inner buttocks fold. intact. NA-B perform protective barrier or brief. During in interview a stated that it was no incontinent when R that R39 was last cf was placed in his w	ted 7/2/15 identified "has wel and bladder] - has of when he voids, but this is e CVA. He has no awareness ments." R39's care plan at R39 was to be "resident will anged with repositioning." s on 10/27/2015 at 6:29 p.m., seated in his wheel chair, in nd visiting with family following During continuous observation I 7:41 p.m., (one hour and 12 ined in the activity area until 89, seated in the wheel chair, room by family. R39 and ted in the room until 7:47 p.m., member left, and activated 7:49 p.m. nursing assistant 39's call light and went to for R39's evening cares. From	F	315			

If continuation sheet Page 17 of 18

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/04/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245410	B. WING			10/2	29/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RICE CA	RE CENTER				801 SOUTHWEST WILLMAR AVENUE VILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	and changed every During interview on director of nursing a they had interviewe R39 in his wheel ch 5:25 p.m. and indic change resident wh R39 was assessed checked and change	ted R39 was to be checked 2 hours with his repositioned. 10/27/15 at 8:43 p.m., the and CM-A, stated that when d NA-A and NA-B had placed air before the evening meal at ated they did not check and lile R39 was with family. by the facility to need to be ged every 2 hours when ver was not repositioned for 2	F3	315			

Facility ID: 00313

If continuation sheet Page 18 of 18

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 6 01 - MAIN BUILDING 01		E SURVEY	
		245410	B. WING		10/	27/2015	
	PROVIDER OR SUPPLIER	13	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET DATE	
Κ 000	Minnesota Departm Fire Marshal Division Rice Care Center - in compliance with participation in Med Subpart 483.70(a), 2000 edition of Natt Association (NFPA Code (LSC), Chap The facility was ins buildings: Rice Care Center - building with no bas at 6 different times, constructed in 1968 Type II(111) constru- was constructed or building and was do construction. Since	Survey was conducted by the nent of Public Safety, State on. At the time of this survey, Building 01, was found to be the requirements for dicare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection) Standard 101, Life Safety oter 19 Existing Health Care. pected as two separate Building 01, is a 1-story sement that was constructed The original building was 5 and was determined to be of uction. In 1995, an addition in the south side of the original etermined to be of Type II(111) e the original building and the both Type II (111) construction	К 000				
	they were both insp Existing Healthcare The facility is equip that has smoke det spaces that are op monitored for autor notification. The fa automatic fire sprin	pected as Building 01 under		EPOC			

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.

			ION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 245410 B. WING 10/27/2015 R SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1801 SOUTHWEST WILLMAR AVENUE 1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201 WILLMAR, MN 56201						
	STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY	
	245410		B. WING			10/27/2015			
ł	NAME OF F	PROVIDER OR SUPPLIER							
	RICE CA								
	(X4) ID PREFIX TAG	(EACH DEFICIENC)	AND HUMAN SERVICES FORM AF & MEDICAID SERVICES OMB NO. 09 X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 (X3) DATE S COMPLI 245410 B. WING 10/27 STREET ADDRESS, CITY, STATE, ZIP CODE 1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201 10/27 EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) O Je 1 K 000 K 000 K 000 K 000	(X5) COMPLETION DATE					
	K 000	•	42 CFR, Subpart 483.70(a) is	K	000	3			
								ě.	
								5	
						т: 1			
9									
			3						

Facility ID: 00313

If continuation sheet Page 2 of 2

PRINTED: 11/30/2015

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DA	TE SURVEY	
	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 02 - 2011 ADDITION			COMPLETED	
		245410	B. WING			/27/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC 1801 SOUTHWEST WILLMAR AVENU			
RICE CAI	RE CENTER			WILLMAR, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
K 000	INITIAL COMMEN	ſS	K 00	00			
	FIRE SAFETY						
	Minnesota Departn Fire Marshal Division the Rice Care Cent were found not in s requirements for par Medicare/Medicaid 483.70(a), Life Safe edition of National	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO:	THE PLAN OF R THE FIRE SAFETY		.4			
	Angela.Kappenma	Division Suite 145 -5145, or state.mn.us itney@state.mn.us> and		EPO	2		
	DEFICIENCY MUS						
	1. A description of	what has been, or will be, done					

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.

		AND HUMAN SERVICES		0		PPROVED	
						(3) DATE SURVEY COMPLETED	
		245410	B. WING		10/2	7/2015	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1801 SOUTHWEST WILLMAR AVENUE			
RICE CA	RE CENTER			WILLMAR, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 000	to correct the defici 2. The actual, or pro 3. The name and/o responsible for corr	ency. oposed, completion date.	К 00	0			
	buildings: The Rice Care Cen five separate additi four different times. The first addition with located on the sout determined to be or The second additio 1-story addition with located on the sout Building - 01 and w V(111) construction in 2013, and is a 1- basement that is lo northwest wing of E determined to be or The fourth addition building that were to additions are 1-stor that are located on and on the west sid determined that bo V(111) construction Since the five addit	as built in 2011, and is a hout a basement that is h side of Building - 01 and was f Type V(111) construction. n was built in 2012, and is a hout a basement that is h side of the northeast wing of ras determined to be of Type h. The third addition was built story addition without a cated on the south side of the Building - 01 and was f Type V(111) construction. to the facility consisted of two both built in 2014, both ry additions without basements the west side of Building - 01 de of the 2011 addition. It was th 2014 additions are of Type h.					
	Type V(111) constr	uction, they were inspected as d as Building - 03 and to New					

If continuation sheet Page 2 of 4

PRINTED: 11/30/2015

PRINTED: 11/30/2015 FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES DICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAND (X1) PROVIDER OLDEA DENTRICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 02 - 2011 ADDITION (X3) OLDEA COMPLETED NAME OF PROVIDER OR SUPPLIER 245410 International Construction A BUILDING 02 - 2011 ADDITION (X3) OLDEA BUILDING 02 - 2011 ADDITION (X3) OLDEA COMPLETED NAME OF PROVIDER OR SUPPLIER International Construction (X4) ID PREIDE TAG STREET ADDRESS, CITY, STATE 20P CODE 1981 SOUTHWEST WILLMAR, MN SKREWER OF DEFICIENCIES (X4) ID PREIDE ADDRESS VIEW OF CONFECTION (X4) ID PREIDE ADDRESS VIEW OF CONFECTION (X4) ID PREIDE TAG STREET ADDRESS, CITY, STATE 20P CODE 1981 SOUTHWEST WILLMAR, MN SKREWER (X4) ID PREIDE ADDRESS VIEW OF CONFECTION (X500 CONTENTION INSTEE PRECEDED & FILL (X4) ID PREIDE ADDRESS VIEW OF CONFECTION (X500 CONTENTION) STREET ADDRESS, CITY, STATE 20P CODE 1981 SOUTHWEST WILLMAR, MN SKREWER (X500 CONTENTION) CONTENTION (X500 CONTENTION)	CENTER	SFOR MEDICARE	& MEDICAID SERVICES	OIVID NO. 0930-0391					
MAKE OF PROMDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE RICE CARE CENTER STREET ADDRESS, CITY, STATE, ZP CODE IVAIID PROVIDER'S VALUAR AVENUE VILLIAR, NM 56201 PROVIDER'S VALUAR AVENUE VILLIAR, NG 50201 VALUAR AVENUE	IDENTIFICATION NUMBER								
RICE CARE CENTER 1801 SOUTHWEST WILLMAR AVENUE WILLMAR, NM 56201 PHEERX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MIST BE PRECEDED BY FULL (EACH DEPICIENCY MIST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) 000000000000000000000000000000000000			245410	B. WING			0/27/2015		
RICE CARE CENTER WILLMAR, MN 56201 (X4) D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH EDFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PD PROVIDENT ACTION SHOULD BE CARDESTREEMENCED TO THE APPROPRIME DEFICIENCY Continued PROVIDENT ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME DEFICIENCY Continued PROVIDENT ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIME SHOULD ACTION THE ASSENCE The requirement at 42 CFR, Subpart 483.70(a) is NOT MET. K 147 K 147 K 147 NFPA 101 LIFE SAFETY CODE STANDARD Floating and equipment is in accordance with NFPA 70, National Electrical Installations are not in accordance by: Based on observation and interview, electrical Installations are not in accordance by: Based on observation and interview, electrical Installations are not in accordance with NFPA 70 "The National Electrical Code 1999 edition. section 9.1.2. This deficiency could negatively effect the 6 of 76 residents. An electrician installed a 4-plex outlet to plug in refrigerator and f	NAME OF PROVIDER OR SUPPLIER								
(M) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL FAG D PREFX TAG D PREF	RICE CARE CENTER								
Margin EACL DEPICIENCY MUST BE PRECEDED BY FULL REQUATORY OR LSC IDENTIFYING INFORMATION) PRETX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMMENTION DATE K 000 Continued From page 2 Health Care facility standards. K 000 K 000 The facility is equipped with a fire alarm system that has smoke detection in the corridors and in spaces that are open to the corridors. The facility's fire alarm system is also monitored for automatic fire opention. The facility is fully protected by an automatic fire spinkler system. At the time of the inspection the facility has a capacity of 78 beds and had a census of 75. K 147 10/29/15 K 147 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET. K 147 An electrician installed a 4-plex outlet to plug in refrigerator and freezer. This STANDARD is not met as evidenced by: Based on observation and interview, electrical installations are not in accordance with NFPA 70. An electrician installed a 4-plex outlet to plug in refrigerator and freezer. The National Electrical Code 1999 edition. section 9.1.2. This deficiency could negatively effect the 6 of 76 residents. H is the policy of Rice Care Center to prohibit the use of power strips in plugging in appliances. Maintenance will be responsible for auditing the building to ensure compliance. Findings will reported to Quality Assurance.	(MA) 15			ID			(X5)		
Health Care facility standards. The facility is equipped with a fire alarm system that has smoke detection in the corridors and in spaces that are open to the corridors. The facility's fire alarm system is also monitored for automatic fire department notification. The facility is fully protected by an automatic fire sprinkler system. At the time of the inspection the facility has a capacity of 78 beds and had a census of 75. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET. NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview. electrical installations are not in accordance with NFPA 70. "The National Electrical Code 1999 edition. section 9.1.2. This deficiency could negatively effect the 6 of 76 residents. Findings include: On facility tour between 10:00 AM and 02:00 PM on 10/27/2015, it was observed: 1. Refrigerator was plugged into a power strip in	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION		
 Based on observation and interview, electrical installations are not in accordance with NFPA 70 "The National Electrical Code 1999 edition. section 9.1.2. This deficiency could negatively effect the 6 of 76 residents. Findings include: On facility tour between 10:00 AM and 02:00 PM on 10/27/2015, it was observed: 1. Refrigerator was plugged into a power strip in 	К 147	Health Care facility The facility is equip that has smoke det spaces that are ope facility's fire alarm s automatic fire depa is fully protected by system. At the time has a capacity of 76 75. The requirement at NOT MET. NFPA 101 LIFE SA Electrical wiring and	standards. ped with a fire alarm system section in the corridors and in en to the corridors. The system is also monitored for intment notification. The facility an automatic fire sprinkler e of the inspection the facility 8 beds and had a census of : 42 CFR, Subpart 483.70(a) is FETY CODE STANDARD d equipment is in accordance				10/29/15		
This deficient practice was verified by Maintenance Supervisor (RW)		This STANDARD is not met as evidenced by: Based on observation and interview, electrical installations are not in accordance with NFPA 70 "The National Electrical Code 1999 edition. section 9.1.2. This deficiency could negatively effect the 6 of 76 residents. Findings include: On facility tour between 10:00 AM and 02:00 PM on 10/27/2015, it was observed: 1. Refrigerator was plugged into a power strip in the charting room by Therapy Services. This deficient practice was verified by				plug in refrigerator and freezer. It is the policy of Rice Care Center to prohibit the use of power strips in plugg in appliances. Maintenance will be responsible for auditing the building to ensure compliance. Findings will repor	ing		
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 51X621 Facility ID: 00313 If continuation sheet Page 3 of		567(02.00) Providua Varaiana	Obsolete Event ID: 51¥62	1	Fa	cility ID: 00313	sheet Page 3 of 4		

FORM CMS-2567(02-99) Previous Versions Obsolete

		& MEDICAID SERVICES				APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DAT A. BUILDING 02 - 2011 ADDITION			TE SURVEY MPLETED	
		245410	B. WING		10/	27/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C			
RICE CA	RE CENTER			1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
						5	
	567/02-99) Previous Versions	Obsolete Event ID: 51X	604	Facility ID: 00313	If continuation sh	eet Page 4 of	

PRINTED: 11/30/2015



November 18, 2015

Ms. Pam Adam, Administrator Rice Care Center 1801 Southwest Willmar Avenue Willmar, Minnesota 56201

Re: Enclosed State Licensing Orders - Project Number S5410025

Dear Ms. Adam:

The above facility was surveyed on October 26, 2015 through October 29, 2015 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation 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 144.56. 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.

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 Supervised Living Facilities.

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 is 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 first page of the order form should be signed and returned to this office at Minnesota Department of Health, P.O. Box 64900, St. Paul, Minnesota 55164-0900. 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 Brenda Fischer at (320)223-7338. A written plan for correction of licensing orders

Protecting, Maintaining and Improving the Health of Minnesotans Minnesota Department of Health • Health Regulation Division General Information: 651-201-5000 • Toll-free: 888-345-0823 http://www.health.state.mn.us An equal opportunity employer Rice Care Center November 18, 2015 Page 2

is not required.

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.

Feel free to contact me with any questions related to this letter.

Sincerely,

Vate Compton

Kate JohnsTon, Program Specialist Licensing and Certification Program Health Regulation Division kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00313	B. WING		10/2	9/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RICE CA	RE CENTER		THWEST W	ILLMAR AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
Minnecoto D	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE

Electronically Signed

STATE FORM

6899

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00313	B. WING		10/	10/29/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE			
RICE CA	RE CENTER		UTHWEST WIL R, MN 56201	LMAR AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 000	Department of Hea you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th corrected prior to e Minnesota Departm On October 26-29ti Department's staff, the following correct Please indicate in y correction that you and identify the dat Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag m column entitled "ID statute/rule out of co "Summary Stateme and replaces the "T	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. h, 2015 surveyors of this visited the above provider and to orders are issued. Your electronic plan of have reviewed these orders, e when they will be completed. nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for umber appears in the far left o Prefix Tag." The state compliance is listed in the ent of Deficiencies" column to Comply" portion of the					
	findings which are i after the statement evidence by." Follo are the Suggested Time period for Con						
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00313	B. WING		10//	10/29/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
RICE CA	RE CENTER		UTHWEST WIL R, MN 56201	LMAR AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 000	Continued From pa	ige 2	2 000				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.					
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565				
		omprehensive plan of care I personnel involved in the					
	by: Based on observati review, the facility f the plan of care for identified at risk for timely repositioned to ensure staff follo	ent is not met as evidenced ion, interview and document ailed to ensure staff followed 1 of 3 residents, (R39) pressure ulcers, who was not . In addition, the facility failed wed the plan of care for 1 of 3 iewed who required eting.					
	Findings include:						
	7/09/15, indicated F cognitively impaired assistance with tran bed and in wheelch accident (CVA) and	inimum data set (MDS), dated R39 was moderately d, required extensive nsferring and repositioning in hair due to cerebral vascular I was at risk for pressure ulcer and urinary incontinence.					
	dated 7/10/15, indic	essment for Pressure Ulcers, cated: "resident is at risk for lated to] requiring extensive					

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00313	B. WING		10/	10/29/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE	·		
RICE CA	RE CENTER		JTHWEST WII R, MN 56201	LLMAR AVENUE			
(X4) ID	SUMMABY STA			PROVIDER'S PLAN OF	COBBECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY	WUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET	
2 565	Continued From pa	ge 3	2 565				
	incontinence of [boy admitted to the faci moisture on coccyx The care area asse Incontinence, dated has bladder [incont post] [cerebral vasc feel the sensation n of the time. [Occasi to void, and then wi accurate when he h currently two remai open area. Require [incontinence] and I R39's care plan dat for skin breakdown incontinence, and w open areas under s R39's care plan furt be "turned [and] rep	d 7/10/15, indicated: "resident inence] [related to] [status cular accident]. He does not nost of passing his urine most ionally he will state he needs ill not. Rarely he will be has asked for urinal. He has ning open moisture [related to] s assist to manage his bed mobility." ted 7/2/15 identified "Is at risk [related to] immobility, vearing of a splint. [History] of scrotum, coccyx and heel." ther indicated that R39 was to position every two hours. Is to boots on at all times, expect					
	[occasional] feeling not consistent since of his [bowel mover further indicated tha be checked and cha During observations	ther identified: "has wel and bladder] - has of when he voids, but this is e CVA. He has no awareness ments." R39's care plan at R39 was to be "resident will anged with repositioning." s on 10/27/2015 at 6:29 p.m., seated in his wheel chair, in					
	the activity room an the evening meal. I from 6:29 p.m. until minutes) R39 rema	d visiting with family following During continuous observation 7:41 p.m., (one hour and 12 ined in the activity area until 9, seated in the wheel chair,					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00313	B. WING		10/	10/29/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE			
RICE CA	RE CENTER		UTHWEST WII R, MN 56201	LMAR AVENUE			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT		ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	was returned to his family member visi when R39's family R39's call light. At (NA)-A answered F retrieve more help 7:52 p.m. until 8:10 evening cares, whil wheel chair. At 8:10 lift, NA-A and NA-B p.m., once on his f NA-B removed a he brief, reveling a rec inner buttocks fold. intact. NA-B perform	age 4 age 4 a room by family. R39 and ted in the room until 7:47 p.m., member left, and activated 7:49 p.m. nursing assistant R39's call light and went to for R39's evening cares. From p.m. NA-A and NA-B provided le R39 remained seated in his p.m., with use of the room b placed R39 in bed. At 8:14 bed and on R39's left side, eavily saturated incontinent Idened coccyx and bilateral R39's skin, however, was med peri-care, applied a ream, and reapplied a new	1				
	stated that it was n reddened in the are care. NA-B stated t checked/changed a placed in his wheel p.m. and 5:30 p.m. NA-A and NA-B sta	and repositioned when he was chair for supper between 5:15 earlier this evening. Both ated R39 was to be necked and changed for					
	director of nursing stated that when th NA-B, R39 was pla the evening meal a also indicated R39	n 10/27/15 at 8:43 p.m., the and registered nurse (RN)-A, ley had interviewed NA-A and leed in his wheel chair "before t 5:25 p.m." NA-A and NA-B was not checked/changed or R39's family was present.					
	repositioning and c	by the facility to need hecked and changed for e every 2 hours, however was					

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00313	B. WING	B. WING		10/29/2015	
NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
RICE CA	RE CENTER		UTHWEST WIL R, MN 56201	LMAR AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	age 5	2 565				
	not repositioned for	2 hours and 45 minutes.					
	The director of nurs review and revise p to ensuring the card resident is followed designee could dev staff and develop a staff are providing t the written plan of o	THOD OF CORRECTION: sing (DON) or designee could policies and procedures related e plan for each individual I. The director of nursing or velop a system to update care monitoring system to ensure timely services as directed by care. R CORRECTION: Twenty-one					
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900				
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the jursing care plan which	r				
	without pressure s pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical rates, and a physician they were unavoidable; and					
	receives necessar	who has pressure sores y treatment and services to revent infection, and prevent veloping.					
	This MN Requirem by:	ent is not met as evidenced					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED		
		00313	B. WING	10/29/2015				
NAME OF F	PROVIDER OR SUPPLIER	STREET A	T ADDRESS, CITY, STATE, ZIP CODE					
RICE CA	RE CENTER		UTHWEST WII R, MN 56201	LMAR AVENUE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLE DATE		
2 900	Continued From pa	ige 6	2 900					
	review, the facility f (R39) with history c	ion, interview, and document ailed to ensure 1 of 3 residents of pressure ulcers, were event the development of new						
	Findings include:							
	7/09/15, indicated F cognitively impaired assistance with tran bed and in wheelch accident (CVA) and (PU) development. Pressure Ulcers, da indicated: "resident [related to] requiring bed mobility, he ha [bowel and bladder	is at risk for skin breakdown g extensive assistance with s [frequent] incontinence of] and was admitted to the eas [related to] moisture on						
	(dated 10/07/15) fo continued to be at r breakdown. R39's (Rice Care Center) indicated that R39 Reposition Schedu	recent Skin Risk Assessment r R39 indicated this resident moderate risk for skin Tissue Tolerance Testing RCC - Sitting, dated 10/07/15 was assessed for: "Two Hour le - resident showed no signs ny prominence at the 2 hour						
	for skin breakdown incontinence, and v open areas under s R39's care plan fur be "turned [and] rep	ted 7/2/15 identified "Is at risk [related to] immobility, vearing of a splint. [History] of scrotum, coccyx and heel." ther indicated that R39 was to position every two hours. Is to boots on at all times, expect						

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00313	B. WING		10/29/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
RICE CA	RE CENTER		UTHWEST WII R, MN 56201	LLMAR AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa during bathing / car	-	2 900			
	R39 was observed the activity room ar the evening meal. I from 6:29 p.m. unti minutes) R39 rema 7:41 p.m., when R3 was returned to his family member visi when R39's family R39's call light. At (NA)-A answered F retrieve more help 7:52 p.m. until 8:10 evening cares, whil wheel chair. At 8:10 lift, NA-A and NA-B p.m., once on his b NA-B removed a he brief, reveling a red inner buttocks fold. intact. NA-B perform protective barrier c brief.	s on 10/27/2015 at 6:29 p.m., seated in his wheel chair, in nd visiting with family following During continuous observation I 7:41 p.m., (one hour and 12 ained in the activity area until 39, seated in the wheel chair, 5 room by family. R39 and ted in the room until 7:47 p.m., member left, and activated 7:49 p.m. nursing assistant R39's call light and went to for R39's evening cares. From 0 p.m. NA-A and NA-B provided le R39 remained seated in his 0 p.m., with use of the room 8 placed R39 in bed. At 8:14 bed and on R39's left side, eavily saturated incontinent ddened coccyx and bilateral . R39's skin, however, was med peri-care, applied a ream, and reapplied a new	1			
	stated that it was n reddened in the are care. NA-B stated t when he was place between 5:15 p.m.	at 8:29 p.m., NA-A and NA-B ot uncommon for R39 to be ea noted during evening peri that R39 was last repositioned ed in his wheel chair for supper and 5:30 p.m. earlier this A and NA-B stated R39 was to ery 2 hours.				
	director of nursing	n 10/27/15 at 8:43 p.m., the and CM-A, stated that when ed NA-A and NA-B had placed				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		00313	B. WING		10/	10/29/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
RICE CA	RE CENTER		UTHWEST WIL R, MN 56201	LMAR AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	age 8	2 900				
		nair before the evening meal at ated they did not reposition was with family.	t				
	repositioning every	l by the facility to need 2 hours, however was not nours and 45 minutes.					
	A policy regarding requested, but non	re-positioning of residents was e provided.					
	The director of nurs and review all resid ulcers to assure the treatment/services from developing, a pressure ulcers. T designee, could co monitor nursing ca care-planned interv	THOD OF CORRECTION: sing or designee, could identify dents at risk for pressure ey are receiving the necessary to prevent pressure ulcers nd to promote healing of he director of nursing or nduct random audits to re to ensure appropriate and ventions are implemented and or residents at risk for pressure					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one					
2 910	MN Rule 4658.052 Incontinence	5 Subp. 5 A.B Rehab -	2 910				
	have a continuous management to red unnecessary use o comprehensive res home must ensure A. a resident w	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the sident assessment, a nursing that: who enters a nursing home ng catheter is not catheterized					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00313	B. WING	B. WING		10/29/2015	
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
RICE CA	RE CENTER		UTHWEST WIL R, MN 56201	LMAR AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC [\]	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 910	that catheterization B. a resident w receives appropriat prevent urinary trac	age 9 d's clinical condition indicates was necessary; and ho is incontinent of bladder te treatment and services to ct infections and to restore as der function as possible.	2 910				
	by: Based on observat review, the facility f (R39) with urinary i	ent is not met as evidenced ion, interview, and document ailed to ensure 1 of 3 residents ncontinence was toileted omprehensive assessment.	5				
	7/09/15, indicated I cognitively impaired assistance with trai bed and in wheelch accident (CVA) and bladder. The care a Incontinence, dated indicated: "resident [related to] [status] accident]. He does passing his urine m he will state he nee Rarely he will be ad urinal. He has curre moisture [related to]	inimum data set (MDS), dated R39 was moderately d, required extensive nsferring and repositioning in hair due to cerebral vascular d was frequently incontinent of area assessment for Urinary d 7/10/15, t has bladder [incontinence] post] [cerebral vascular not feel the sensation most of host of the time. [Occasionally eds to void, and then will not. ccurate when he has asked for ently two remaining open o] open area. Requires assist pontinence] and bed mobility."					
	Incontinence (last r	, entitled: Bowel and Bladder reviewed 01/15), indicated that be assessed upon admission					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00313	B. WING		10/	29/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
RICE CA	RE CENTER			LLMAR AVENUE		
			R, MN 56201			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AC		TION SHOULD BE COM THE APPROPRIATE	
2 910	Continued From pa	age 10	2 910			
		continence, and that after the voiding pattern would develop an of care.				
	TENA/SCA Bladder for R39 indicated "r Retraining Program	recent Elimination r Assessment (dated 10/07/15) not appropriate for Toileting or n: - Check and Change with use urinal as requested."				
	incontinence of [bo [occasional] feeling not consistent since of his [bowel mover further indicated that	ted 7/2/15 identified "has wel and bladder] - has of when he voids, but this is e CVA. He has no awareness ments." R39's care plan at R39 was to be "resident will anged with repositioning."				
	R39 was observed the activity room an the evening meal. I from 6:29 p.m. unti minutes) R39 rema 7:41 p.m., when R3 was returned to his family member visit when R39's family R39's call light. At (NA)-A answered F retrieve more help 7:52 p.m. until 8:10 evening cares, whil wheel chair. At 8:10 lift, NA-A and NA-B	s on 10/27/2015 at 6:29 p.m., seated in his wheel chair, in nd visiting with family following During continuous observation I 7:41 p.m., (one hour and 12 tined in the activity area until 39, seated in the wheel chair, room by family. R39 and ted in the room until 7:47 p.m., member left, and activated 7:49 p.m. nursing assistant R39's call light and went to for R39's evening cares. From p.m. NA-A and NA-B provided le R39 remained seated in his 0 p.m., with use of the room s placed R39 in bed. At 8:14	1			
	NA-B removed a he brief, reveling a red inner buttocks fold.	ed and on R39's left side, eavily saturated incontinent Idened coccyx and bilateral R39's skin, however, was med peri-care, applied a				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00313	B. WING		10/	10/29/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•		
RICE CA	RE CENTER		UTHWEST WIL R, MN 56201	LMAR AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE	
2 910	Continued From pa	ge 11	2 910				
	protective barrier cr brief.	eam, and reapplied a new					
	stated that it was no incontinent when Ri that R39 was last cl was placed in his w 5:15 p.m. and 5:30 NA-A and NA-B sta and changed every During interview on director of nursing a they had interviewe R39 in his wheel ch 5:25 p.m. and indica change resident wh R39 was assessed checked and chang	at 8:29 p.m., NA-A and NA-B of uncommon for R39 to be 39 is checked. NA-B stated hecked and changed when he heel chair for supper between p.m. earlier this evening. Both ted R39 was to be checked 2 hours with his repositioned. 10/27/15 at 8:43 p.m., the and CM-A, stated that when d NA-A and NA-B had placed hair before the evening meal at ated they did not check and hile R39 was with family. by the facility to need to be yed every 2 hours when ver was not repositioned for 2 es.					
	The director of nurs all residents at risk assure they are rec treatment/services director of nursing of random audits to er services are implen maintain urinary com	THOD OF CORRECTION: sing or designee, could review for urinary incontinence to eiving the necessary to promote continence. The or designee, could conduct nsure appropriate care and nented to promote and ntinence.					
	(21) days.	TOOTTLOTION. Twenty-one					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00313	B. WING		10/	29/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
RICE CA	RE CENTER		UTHWEST WIL R, MN 56201	LMAR AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21565	Continued From pa	ige 12	21565			
21565	MN Rule 4658.132 Medications Self Ac	5 Subp. 4 Administration of dmin	21565			
	self-administer med resident assessme care as required in 4658.0405 indicate	inistration. A resident may dications if the comprehensive nt and comprehensive plan of parts 4658.0400 and this practice is safe and there om the attending physician.				
	by: Based on observat review, the facility f residents (R11), wit	ent is not met as evidenced ion, interview and document ailed to ensure that 1 of 1 th a self-administration of entirely consumed the et up.				
	Findings include:					
	the diagnoses of A delusions and disruminimum data set (that R11 required e	er report, dated 9/16/15, listed Izheimer's dementia with optive behaviors. The Annual (MDS), dated 8/11/15 indicated xtensive assistance with most ing, and also was severely, d.				
	orders, dated 9/16/ Seroquel (anti-psyc	st recent signed physician's 15, R11 had an order for chotic medication) 25 ery P.M. at supper time - can				
	R11 was sitting at a Cushman Cottage. evening meal, whic glass of water, one	on 10/27/2015 at 5:47 p.m., a table in the dining room in R11 had been served the h included 3 beverages (one glass of orange juice and one n interview at 5:52 p.m.,				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00313	B. WING		10/	29/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
RICE CA	RE CENTER		UTHWEST WIL R, MN 56201	LMAR AVENUE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21565	Continued From pa	ge 13	21565			
	licensed practical n	urse (LPN)-A stated she				
		uel in her orange juice. At				
		ed her napkin on her table,				
		m her table and wheeled				
	"Wheel of Fortune."	om down the hall to watch				
		I ounce of orange juice in				
		er residents, who ate with R11				
		le eating their meals.				
		returned to the dising room				
		returned to the dining room, asked about the medicated				
		the cup by R11. LPN-A was				
		ad not finished the orange				
		ned the Seroquel medication,				
		the glass, took it to the				
	R11 finish taking he	1 sat watching TV and had er medication.				
		icated that R11 had evere dementia with behaviors				
		nallucinations, and both short	3			
		lory loss. The care plan further	-			
		proach, that R11 needed				
		dication administration due to				
		r refusal to take [medication].				
		ted that both R11's Miralax				
	coffee so that she v	nd Seroquel be mixed in vould take it.				
	During interview on	10/29/2015 9:15 a.m.,				
		N)-A stated R11 needed				
	Seroquel for mainta	aining her ability to be involved				
		and also due to R11's				
		ed with paranoia and auditory				
		A stated that R11 will only take				
		morning due to one of her cinations, and R11's physician				
		of Seroquel was more				
		the evening. RN-A said staff				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING			
		00313			10/	29/2015
-			DDRESS, CITY, ST UTHWEST WIL	LMAR AVENUE		
RICE CA	RE CENTER		R, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
21565	Continued From pa	age 14	21565			
		, that when mixing medications erages, that medications were	3			
		on of medication assessment sted from the facility, but RN-A I been completed.				
	Medication, last rev provision for reside impaired, and how	itled Self Administration of vised 12/06, did not include ents, who were cognitively they would be assessed and pliance, when medications are I and fluids.				
	Director of Nursing educate staff on ap instruction to reside self-administration designee could ran	THOD OF CORRECTION: The (DON) or desigee could ppropriate assessment of and ents regarding of medication. The DON or idomly audit medication pass and staff compliance.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
21665	MN Rule 4658.140	0 Physical Environment	21665			
	functional, comforta environment, allow	ust provide a safe, clean, able, and homelike physical ing the resident to use is to the extent possible.				
	by: Based on observat review, the facility f	ent is not met as evidenced ion, interview and document failed to ensure safe water maintained in 2 of 12 resident				

Minneso	ta Department of He	alth				APPROVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
			A. DUILDING.			
		00313	B. WING		10/	29/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
RICE CA	RE CENTER			LLMAR AVENUE		
			R, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLETE DATE
21665	Continued From pa	ge 15	21665			
	rooms in 1 of 3 hou	seholds in the facility.				
	Findings include:					
	p.m. and 5:00 p.m., temperatures were degrees F (Fahrenh degrees F. During p.m., a facility main observed these hot	on 10/26/2015 between 2:30 the following water noted: Room 105 was 120 neit); and room 109 was 120 a revisit to the rooms at 5:15 tenance worker (MW) -A water temperatures: Room f room 109 was 120.7.				
	to 10/26/2015 indic	ncident reports from 11/1/2014 ated there were no residents is or who had incidents related in the facility.				
	the director of nursi no burn-related inci	on 10/26/2015 at 5:30 p.m., ng confirmed there had been dents in the facility during this ng hot water temperatures.				
	MW-B said water te selected rooms wer that practice was di [of this year]. MW- temperature gages maintenance round rooms "would be te the water being too two sources for hot heater serving the r the other was for th for Sophia House a stated that the "set	"were checked daily on our s," and further, individual sted" if there were concerns of hot. MW-B said there were water in the building, one new Therapy Suites area, and e older parts of the building, nd Cushman Cottage. MW-B point" to regulate the hot				
	lowered to 110 deg	in the Therapy Suites "was rees" on Monday this week. point of 110 degrees				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00313	B. WING		10/	29/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
RICE CA	RE CENTER		UTHWEST WII R, MN 56201	LMAR AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21665	maintains the wate 5 degrees," to stay MW-B said before 118 degrees," and from about 113 to 1 set point at the mix water in the "older p "always set" at 110 water in resident ro and 115 degrees." On 10/29/2015 betw the presence of the temperatures from and farthest from th of the three facility resident bathing ro water temperatures degrees F.	age 16 r temperatures "plus or minus in the "105 to 115 range." Monday, the set point "was at the temps would have ranged 23 degrees. MW-B stated the ing valve, regulating the hot part" of the building, was degrees. MW-B said hot ooms should be "between 105 ween 9:45 and 10:00 a.m., in e surveyor, MW-B took water a sample of rooms closest to ne hot water sources on each wings, as well as in common oms. During this time, the s ranged from 107.0 to 112.5 mperature logs from 7/1/2015 eviewed. Logged temperatures				
	in Therapy Suites r degrees F. Tempe [Sophia House and between 110 and 1 In an interview on 1 administrator said r to monitor water ten The administrator s through" regarding	anged between 110 and 124 ratures in the Long Term Care I Cushman Cottage] ranged 23 degrees F. 10/29/2015 at 11:05 a.m., the maintenance was responsible mperatures in resident rooms. stated "I would expect follow checks of the water, and that				
	so that decisions co building and its ope A facility policy, RC directed "To mainta temps [temperature	rt to me any areas of concern" ould be made regarding the erations. C Hot Water Temps, undated, in a safe facility, the hot water es] will be tested every other ident safety and that water				

	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATI	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		00313	B. WING		10/	29/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
RICE CA	RE CENTER		UTHWEST WII R, MN 56201	LLMAR AVENUE		
(X4) ID			ID	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI		(X5) COMPLETI
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO TI DEFICIENCY	HE APPROPRIATE	DATE
21665	Continued From pa	ige 17	21665			
	degrees to 115 deg	nin the safe range of 105 prees [Fahrenheit]." plicy was requested, but none				
	director of nursing (educate staff regard clean, functional an DON or designee, of maintenance and h periodic audits of a ensure a safe, clea	THOD OF CORRECTION: The (DON) or designee, could ding the importance of a safe, ad homelike environment. The could coordinate with ousekeeping staff to conduct reas residents frequent to n, functional and homelike ntained to the extent possible.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21850	MN St. Statute 144 Residents of HC Fa	.651 Subd. 14 Patients & ac.Bill of Rights	21850			
	Residents shall be defined in the Vulne "Maltreatment" mea section 626.5572, s intentional and non physical pain or inju conduct intended to distress. Every res non-therapeutic che except in fully docu authorized in writing resident's physician period of time, and	om from maltreatment. free from maltreatment as erable Adults Protection Act. ans conduct described in subdivision 15, or the -therapeutic infliction of ury, or any persistent course of o produce mental or emotional ident shall also be free from emical and physical restraints, mented emergencies, or as g after examination by a n for a specified and limited only when necessary to t from self-injury or injury to				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00313	B. WING		10/	29/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE	•	
RICE CA	RE CENTER		JTHWEST WII R, MN 56201	LMAR AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIK CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21850	Continued From pa	ge 18	21850			
	by: Based on interview facility failed to repo- immediately to the s residents (R3) alleg Findings include: R3's quarterly Minir 9/29/15, indicated required assist of o daily living. R3's cal identified R3 as a "v did not address are interventions to pro During an interview R3 reported two sta abused her. When "umm, some of th with,they treat me of when handling me." (aide) on the day sh shift. R3 stated show	ent is not met as evidenced y and document review, the ort allegations of abuse state agency for 1 of 3 jations reviewed. mum Data Set, MDS dated she was cognitively intact and ne to two staff for activities of re plan dated 9/29/15 vulnerable adult," however, it as of vulnerability, nor any tect R3 from abuse. on 10/27/15, at 12:56 p.m., aff members in the facility had asked which staff, R3 replied, ne aides I've had problems quite rudely, and are rough " R3 stated there was one nift, and one on the evening e spoke to the nurse manager and "the girl denied it." R3				
	further stated the tr had not improved, a report the other star result from the first	eatment by that staff member and so R3 stated she "did not ff member" due to lack of complaint. R3 further also I would call that abuse when				
		ted R3's allegation of abuse to rator on 10/27/15, at 3:19 p.m.				
	indicated, "It was br	gress Note dated 10/27/15 rought to this writer's attention concern regarding a staff				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00313	B. WING		10/3	29/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
RICE CA	RE CENTER		JTHWEST WII R, MN 56201	LLMAR AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
21850	Continued From pa	ge 19 er. This writer and DON	21850			
	[director of nursing] this concern. Resid concerns. When as when [staff] provide talked to you about anything about it.' T that it was previous member] will not dis resident. Resident s this. Writer had pre staff member] who uncomfortable disc resident. Resident - resident. Resident - resident much. She across the room an swings lift across th resident's bottom in the lift sheet under writer and DON hav for this staff membe past. However, resi happened. Residen when the staff memb suggested that this cares for resident. I is not necessary. R should not have sai explained to her that safe and comfortable feel okay with the s	visited with resident regarding ent initially denied any sked again, she stated, 'It is as my cares.' [R3] stated that, 'I her before, but you did not do 'his writer reminded resident ly discussed that [the staff scuss her personal life with stated she felt offended by viously discussed this with [the				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00313	B. WING		10/	29/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
			THWEST WIL R, MN 56201	LMAR AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
21850	 with R3 who initially then told her about member. RN-A statinformation about si with others inaccura offered to have othe and offered to obse and that two staff gebecause "This is who buring an interview stated that she was instances of abuse outside agencies burguestions regarding? During an interview director of nursing (made by R3 were nagency. The DON room when RN-A speer said she was [R3] didn't like the sistated, "I didn't feel Although, the facility of being mistreated immediately report Agency, but instead allegation. A facility policy, Vuln Prevention, Rice Caindicated its purpos from mistreatment, seclusion and misa The policy directed 	r denied the accusations and concerns with the staff ed, R3 "Will often try to get taff and share the information ately." RN-A further stated she er staff provide care for R3 rve cares with staff and R3 o into the room with R3 nat she does." on 10/28/15, at 8:46 a.m., R3 aware of how to report both in the facility and to the ut declined any further g her previous allegations. on 10/29/15, at 8:46 a.m., the DON) stated the allegations ot reported to the state further stated she was in the poke with R3, and stated, R3 abused by the staff, only that staff member. The DON there was any abuse." y was aware of R3's allegation , the facility did not the incident to the State I began to investigate R3's herable Adult Abuse are Center, dated 7/2015, e was "to protect residents neglect, abuse, involuntary ppropriation of their property." staff to immediately report any the facility administrator and	21850			

Innesota Dep	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ND PLAN OF COR	RECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	· · · · · · · · · · · · · · · · · · ·	СОМ	PLETED
		00313	B. WING		10/	29/2015
IAME OF PROVIDE	R OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
	NTER		UTHWEST WIL R, MN 56201	LMAR AVENUE		
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21850 Conti	nued From pa	age 21	21850			
direct review abuse evalu imple devel broug Comr	or of nursing v/revise polici e and abuse p ating and mor mentation of t oped, with the ht to the facili nittee for revie PERIOD FOI	THOD OF CORRECTION: The or designee, could es and procedures related to prohibition. A system for hitoring consistent these policies could be a results of these audits being ty's Quality Assurance ew. R CORRECTION: Twenty-one				