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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 51X6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — 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 AVENUE**
(L5) **WILLMAR, MN** (L6) **56201**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/11/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	78			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor 12/11/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 01/08/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 01/26/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/04/2015
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

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.

Sincerely,

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

MDH
Minnesota
Department
of Health

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,

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245410	A. Building B. Wing	12/11/2015

Name of Facility	Street Address, City, State, Zip Code
RICE CARE CENTER	1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **11/18/2015**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **11/23/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **11/24/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **11/19/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **11/19/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **11/23/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	01/08/2016	10562	12/11/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/29/2015			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245410	A. Building B. Wing 02 - 2011 ADDITION	12/1/2015

Name of Facility	Street Address, City, State, Zip Code
RICE CARE CENTER	1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 10/29/2015	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By KS/KJ	Date: 01/08/2016	Signature of Surveyor: 34764	Date: 12/01/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 10/27/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 51X6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — 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 AVENUE**
(L5) **WILLMAR, MN** (L6) **56201**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/29/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **78** (L18)

13.Total Certified Beds **78** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	78			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Bruce Melchert, HFE NE II — 11/18/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 12/03/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 12/04/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH Minnesota Department of Health

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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.

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:

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING _____ B. WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICE CARE CENTER	1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that 1 of 1 residents (R11), with a self-administration of medication order, entirely consumed the medications after set up. Findings include: R11' physician order report, dated 9/16/15, listed the diagnoses of Alzheimer's dementia with delusions and disruptive behaviors. The Annual minimum data set (MDS), dated 8/11/15 indicated that R11 required extensive assistance with most	F 176	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	11/18/15

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

Electronically Signed | 11/28/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING _____ B. WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 176	Continued From page 1 activities of daily living, and also was severely, cognitively impaired. In review of the most recent signed physician's orders, dated 9/16/15, R11 had an order for Seroquel (anti-psychotic medication) 25 milligrams (mg) every P.M. at supper time - can mix in coffee. During observation on 10/27/2015 at 5:47 p.m., R11 was sitting at a table in the dining room in Cushman Cottage. R11 had been served the evening meal, which included 3 beverages (one glass of water, one glass of orange juice and one cup of coffee). In an interview at 5:52 p.m., licensed practical nurse (LPN)-A stated she placed R11's Seroquel in her orange juice. At 6:01 p.m., R11 placed her napkin on her table, pushed her way from her table and wheeled herself to the dayroom down the hall to watch "Wheel of Fortune." There remained approximately 1/2-1 ounce of orange juice in R11's cup. Two other residents, who ate with R11, remained at the table eating their meals. At 6:10 p.m. LPN-A returned to the dining room, when the surveyor asked about the medicated orange juice left in the cup by R11. LPN-A was unaware that R11 had not finished the orange juice, which contained the Seroquel medication, and after grabbing the glass, took it to the dayroom where R11 sat watching TV and had R11 finish taking her medication. R11's care plan indicated that R11 had Alzheimer's, with severe dementia with behaviors, paranoia, auditory hallucinations, and both short and long term memory loss. The care plan further indicated, as an approach, that R11 needed	F 176	medication assessment is completed and physician orders are in place. Corrective action to prevent reoccurrence: Self-administration of medication policy and procedure reviewed at Nurses/TMA meeting 11/19/2015. Education regarding the need to go back and check on the residents to assure their medications have been taken per policy. Monitoring for Compliance: DON or designee will audit residents that are self-administering medications after set up are taken completely per policy. Audits will be completed twice a week for one month then weekly for one month on various shifts. The results of these audits will be discussed and reviewed at QA who will determine when compliance is indicated.	

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F 176	Continued From page 2 assistance with medication administration due to poor vision, and her refusal to take [medication]. The approach directed that both R11's Miralax (powder laxative) and Seroquel be mixed in coffee so that she would take it. During interview on 10/29/2015 9:15 a.m., registered nurse (RN)-A stated R11 needed Seroquel for maintaining her ability to be involved in her environment, and also due to R11's behaviors associated with paranoia and auditory hallucinations. RN-A stated that R11 will only take medications in the morning due to one of her prior auditory hallucinations, and R11's physician felt the single dose of Seroquel was more beneficial for R11 in the evening. RN-A said staff need to make sure, that when mixing medications in food and/or beverages, that medications were consumed totally. A self administration of medication assessment for R11 was requested from the facility, but RN-A indicated none had been completed. A facility Policy entitled Self Administration of Medication, last revised 12/06, did not include provision for residents, who were cognitively impaired, and how they would be assessed and monitored for compliance, when medications are placed in their food and fluids.	F 176		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide	F 225		11/23/15

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F 225	Continued From page 3 registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report allegations of abuse immediately to the state agency for 1 of 3 residents (R3) allegations reviewed.	F 225	Corrective Action: A Vulnerable Adult report was filed with MDH/OHFC on 10/29/2015 for resident 3. Investigation followed report to	

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F 225	Continued From page 4 Findings include: R3's quarterly Minimum Data Set, MDS dated 9/29/15, indicated she was cognitively intact and required assist of one to two staff for activities of daily living. R3's care plan dated 9/29/15 identified R3 as a "vulnerable adult," however, it did not address areas of vulnerability, nor any interventions to protect R3 from abuse. During an interview on 10/27/15, at 12:56 p.m., R3 reported two staff members in the facility had abused her. When asked which staff, R3 replied, "ummm, some of the aides I've had problems with,they treat me quite rudely, and are rough when handling me." R3 stated there was one (aide) on the day shift, and one on the evening shift. R3 stated she spoke to the nurse manager about one of them, and "the girl denied it." R3 further stated the treatment by that staff member had not improved, and so R3 stated she "did not report the other staff member" due to lack of result from the first complaint. R3 further also said, "I don't like it, I would call that abuse when they are so mean to me." The surveyor reported R3's allegation of abuse to the facility administrator on 10/27/15, at 3:19 p.m. Review of R3's Progress Note dated 10/27/15 indicated, "It was brought to this writer's attention that resident had a concern regarding a staff member abusing her. This writer and DON [director of nursing] visited with resident regarding this concern. Resident initially denied any concerns. When asked again, she stated, 'It is when [staff] provides my cares.' [R3] stated that, 'I talked to you about her before, but you did not do anything about it.' This writer reminded resident	F 225	MDH/OHFC. Corrective Action to Prevent reoccurrence: The Vulnerable Adult Abuse Prevention Policy and Procedure has been revised to 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. Monitoring for Compliance: Current Policy and Procedure states following report of Vulnerable Adult Abuse and Neglect, immediately notify the DON and Administrator. Since the DON and Administrator are notified immediately following the VA report, we can ensure the report was filed immediately. Members of the Vulnerable Adult Committee (Administrator, DON, or Social Services) will audit Vulnerable Adult reporting	

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F 225	Continued From page 5 that it was previously discussed that [the staff member] will not discuss her personal life with resident. Resident stated she felt offended by this. Writer had previously discussed this with [the staff member] who stated that she felt uncomfortable discussing her personal life with resident. Resident then stated [the staff member] is rude to resident -i.e.- she does not talk to resident much. She throws resident's clothes across the room and/or shoes in the closet. She swings lift across the room. She refuses to wash resident's bottom in the shower. She does not put the lift sheet under the resident comfortably. This writer and DON have both heard resident request for this staff member to provide her cares in the past. However, resident denies that this has ever happened. Resident stated that she felt stressed when the staff member was in providing her care. This writer informed resident that she would talk with the staff member about these concerns and suggested that this writer observe staff providing cares for resident. Resident refused, stating this is not necessary. Resident stated, 'I knew I should not have said anything.' This writer explained to her that it is important that she feel safe and comfortable here, and that she need to feel okay with the staff that care for her." During and interview on 10/28/15, at 1:02 p.m., registered nurse (RN)-A stated, "It was brought to my attention by the administrator that R3 had a complaint." RN-A stated R3 had not reported an instance of abuse to her previously. She spoke with R3 who initially denied the accusations and then told her about concerns with the staff member. RN-A stated, R3 "Will often try to get information about staff and share the information with others inaccurately." RN-A further stated she offered to have other staff provide care for R3	F 225	documentation for completeness and timeliness of reporting. The DON or designee will report compliance to the QA committee.	

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F 225	Continued From page 6 and offered to observe cares with staff and R3 and that two staff go into the room with R3 because "This is what she does." During an interview on 10/28/15, at 8:46 a.m., R3 stated that she was aware of how to report instances of abuse both in the facility and to the outside agencies but declined any further questions regarding her previous allegations. During an interview on 10/29/15, at 8:46 a.m., the director of nursing (DON) stated the allegations made by R3 were not reported to the state agency. The DON further stated she was in the room when RN-A spoke with R3, and stated, R3 never said she was abused by the staff, only that [R3] didn't like the staff member. The DON stated, "I didn't feel there was any abuse." Although, the facility was aware of R3's allegation of being mistreated, the facility did not immediately report the incident to the State Agency, but instead began to investigate R3's allegation. A facility policy, Vulnerable Adult Abuse Prevention, Rice Care Center, dated 7/2015, indicated its purpose was "to protect residents from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of their property." The policy directed staff to immediately report any suspected abuse to the facility administrator and to the state agency.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit	F 226		11/24/15

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F 226	Continued From page 7 mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the stage agency was notified immediately of an allegation of abuse as directed by facility policy for 1 of 3 resident allegations reviewed. Findings include: A facility policy, Vulnerable Adult Abuse Prevention, Rice Care Center, dated 7/2015, indicated its purpose was "to protect residents from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of their property." The policy directed staff to immediately report any suspected abuse to the facility administrator and to the state agency. During an interview on 10/27/15, at 12:56 p.m., R3 told the surveyor, two staff members in the facility had abused her. When asked which staff, R3 replied, "Ummm, some of the aides I've had problems with,they treat me quite rudely, and are rough when handling me." R3 said there was one [aide] on the day shift, and one on the evening shift. R3 stated she spoke to the nurse manager about one of them, and stated "the girl denied it." R3 further stated the treatment by that staff member had not improved, and so R3 stated she "did not report the other staff member" due to lack of result from the first one. R3 further also said, "I don't like it, I would call that abuse when they are so mean to me."	F 226	Corrective Action: A Vulnerable Adult report was filed with MDH/OHFC on 10/29/2015 for resident 3. Investigation followed report to MDH/OHFC. Corrective Action to Prevent reoccurrence: The Vulnerable Adult Abuse Prevention Policy and Procedure has been revised to 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.	

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F 226	Continued From page 8 The surveyor reported R3's allegation of abuse to the facility administrator on 10/27/15, at 3:19 p.m. During and interview on 10/28/15, at 1:02 p.m., registered nurse (RN)-A stated, "It was brought to my attention by the administrator that R3 had a complaint." RN-A said she spoke with R3, who initially denied the accusations, but then spoke of her about concerns with the staff member. During an interview on 10/29/15, at 8:46 a.m., the director of nursing (DON) stated the allegations made by R3 were not reported to the state agency. The DON stated she was in the room when RN-A spoke with R3 and stated, R3 never said she was abused by the staff, only that she didn't like the staff member. The DON stated, "I didn't feel there was any abuse." The DON further stated, when abuse is suspected or reported, staff are educated to protect the resident first, then report to the administrator and file a report with the state agency. The DON further stated, "If I would get a call when I'm not in the building, we would report and then investigate," and added, "If I'm in the building, I feel I can get involved and then make a decision." Although the facility was aware of R3's allegation of being mistreated, the facility did not immediately report the incident to the State Agency as directed by the facility polcy, but instead began to investigate R3's allegation.	F 226	Monitoring for Compliance: Current Policy and Procedure states following report of Vulnerable Adult Abuse and Neglect, immediately notify the DON and Administrator. Since the DON and Administrator are notified immediately following the VA report, we can ensure the report was filed immediately. Members of the Vulnerable Adult Committee (Administrator, DON, or Social Services) will audit Vulnerable Adult reporting documentation for completeness and timeliness of reporting. The DON or designee will report compliance to the QA committee.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282		11/19/15

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F 282	Continued From page 9 must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff followed the plan of care for 1 of 3 residents, (R39) identified at risk for pressure ulcers, who was not timely repositioned. In addition, the facility failed to ensure staff followed the plan of care for 1 of 3 residents (R39) reviewed who required assistance with toileting. Findings include: R39's admission minimum data set (MDS), dated 7/09/15, indicated R39 was moderately cognitively impaired, required extensive assistance with transferring and repositioning in bed and in wheelchair due to cerebral vascular accident (CVA) and was at risk for pressure ulcer (PU) development and urinary incontinence. The care area assessment for Pressure Ulcers, dated 7/10/15, indicated: "resident is at risk for skin breakdown [related to] requiring extensive assistance with bed mobility, he has [frequent] incontinence of [bowel and bladder] and was admitted to the facility with open areas [related to] moisture on coccyx [and] peri area (scrotum)." The care area assessment for Urinary Incontinence, dated 7/10/15, indicated: "resident has bladder [incontinence] [related to] [status post] [cerebral vascular accident]. He does not feel the sensation most of passing his urine most of the time. [Occasionally he will state he needs	F 282	F 282 Services By Qualified Person/s Per Care Plan Corrective Action: Staff has been educated for resident 39 if he is with family staff need to interrupt the family time and reposition and check and change for urinary incontinence every 2 hour per care plan. Correction Action-identify other residents: Care plans of dependent residents were reviewed for reposition time according to tissue tolerance sitting & lying and checking/ changing according to Bowel and bladder assessments. . An individualized repositioning plan and toileting scheduled devised based on resident assessment. Corrective action to Prevent reoccurrence: Mandatory education to all nursing staff regarding the need to follow the resident care plan for repositioning for residents identified at risk for skin break down and toileting scheduled. Resident roster will continue to identify the bottoms up heart shape by resident name and how many hours between repositioning . Monitoring for Compliance: DON or Designee will audit residents that need to be repositioned every two hours	

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F 282	Continued From page 10 to void, and then will not. Rarely he will be accurate when he has asked for urinal. He has currently two remaining open moisture [related to] open area. Requires assist to manage his [incontinence] and bed mobility." R39's care plan dated 7/2/15 identified "Is at risk for skin breakdown [related to] immobility, incontinence, and wearing of a splint. [History] of open areas under scrotum, coccyx and heel." R39's care plan further indicated that R39 was to be "turned [and] reposition every two hours. Is to have heel protector boots on at all times, expect during bathing/cares." R39's care plan further identified: "has incontinence of [bowel and bladder] - has [occasional] feeling of when he voids, but this is not consistent since CVA. He has no awareness of his [bowel movements." R39's care plan further indicated that R39 was to be "resident will be checked and changed with repositioning." During observations on 10/27/2015 at 6:29 p.m., R39 was observed seated in his wheel chair, in the activity room and visiting with family following the evening meal. During continuous observation from 6:29 p.m. until 7:41 p.m., (one hour and 12 minutes) R39 remained in the activity area until 7:41 p.m., when R39, seated in the wheel chair, was returned to his room by family. R39 and family member visited in the room until 7:47 p.m., when R39's family member left, and activated R39's call light. At 7:49 p.m. nursing assistant (NA)-A answered R39's call light and went to retrieve more help for R39's evening cares. From 7:52 p.m. until 8:10 p.m. NA-A and NA-B provided evening cares, while R39 remained seated in his wheel chair. At 8:10 p.m., with use of the room	F 282	or less according to care plan. Audits will be done weekly for 4 weeks then twice a month for 1 month then monthly till stable. Results will be brought to QA committee for recommendation on the need to further audit.	

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F 282	Continued From page 11 lift, NA-A and NA-B placed R39 in bed. At 8:14 p.m., once on his bed and on R39's left side, NA-B removed a heavily saturated incontinent brief, reveling a reddened coccyx and bilateral inner buttocks fold. R39's skin, however, was intact. NA-B performed peri-care, applied a protective barrier cream, and reapplied a new brief. During in interview at 8:29 p.m., NA-A and NA-B stated that it was not uncommon for R39 to be reddened in the area noted during evening peri care. NA-B stated that R39 was last checked/changed and repositioned when he was placed in his wheel chair for supper between 5:15 p.m. and 5:30 p.m. earlier this evening. Both NA-A and NA-B stated R39 was to be repositioned and checked and changed for urinary incontinence every 2 hours. During interview on 10/27/15 at 8:43 p.m., the director of nursing and registered nurse (RN)-A, stated that when they had interviewed NA-A and NA-B, R39 was placed in his wheel chair "before the evening meal at 5:25 p.m." NA-A and NA-B also indicated R39 was not checked/changed or repositioned while R39's family was present. R39 was assessed by the facility to need repositioning and checked and changed for urinary incontinence every 2 hours, however was not repositioned for 2 hours and 45 minutes.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores	F 314		11/19/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING _____ B. WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICE CARE CENTER	1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 12 does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R39) with history of pressure ulcers, were provided care to prevent the development of new pressure ulcers. Findings include: R39's admission minimum data set (MDS), dated 7/09/15, indicated R39 was moderately cognitively impaired, required extensive assistance with transferring and repositioning in bed and in wheelchair due to cerebral vascular accident (CVA) and was at risk for pressure ulcer (PU) development. The care area assessment for Pressure Ulcers, dated 7/10/15, indicated: "resident is at risk for skin breakdown [related to] requiring extensive assistance with bed mobility, he has [frequent] incontinence of [bowel and bladder] and was admitted to the facility with open areas [related to] moisture on coccyx [and] peri area (scrotum)." The facility's most recent Skin Risk Assessment (dated 10/07/15) for R39 indicated this resident continued to be at moderate risk for skin breakdown. R39's Tissue Tolerance Testing RCC (Rice Care Center) - Sitting, dated 10/07/15 indicated that R39 was assessed for: "Two Hour	F 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	

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RICE CARE CENTER	1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201

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F 314	Continued From page 13 Reposition Schedule - resident showed no signs of redness over bony prominence at the 2 hour assessment." R39's care plan dated 7/2/15 identified "Is at risk for skin breakdown [related to] immobility, incontinence, and wearing of a splint. [History] of open areas under scrotum, coccyx and heel." R39's care plan further indicated that R39 was to be "turned [and] reposition every two hours. Is to have heel protector boots on at all times, expect during bathing / cares." During observations on 10/27/2015 at 6:29 p.m., R39 was observed seated in his wheel chair, in the activity room and visiting with family following the evening meal. During continuous observation from 6:29 p.m. until 7:41 p.m., (one hour and 12 minutes) R39 remained in the activity area until 7:41 p.m., when R39, seated in the wheel chair, was returned to his room by family. R39 and family member visited in the room until 7:47 p.m., when R39's family member left, and activated R39's call light. At 7:49 p.m. nursing assistant (NA)-A answered R39's call light and went to retrieve more help for R39's evening cares. From 7:52 p.m. until 8:10 p.m. NA-A and NA-B provided evening cares, while R39 remained seated in his wheel chair. At 8:10 p.m., with use of the room lift, NA-A and NA-B placed R39 in bed. At 8:14 p.m., once on his bed and on R39's left side, NA-B removed a heavily saturated incontinent brief, reveling a reddened coccyx and bilateral inner buttocks fold. R39's skin, however, was intact. NA-B performed peri-care, applied a protective barrier cream, and reapplied a new brief.	F 314	Monitoring for Compliance: DON or Designee will audit residents that need to be repositioned every two hours or less according to care plan. Audits will be done weekly for 4 weeks then twice a month for 1 month then monthly till stable. Results will be brought to QA committee for recommendation on the need to further audit.	

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	245410	A. BUILDING _____ B. WING _____	10/29/2015

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F 314	Continued From page 14 During in interview at 8:29 p.m., NA-A and NA-B stated that it was not uncommon for R39 to be reddened in the area noted during evening peri care. NA-B stated that R39 was last repositioned when he was placed in his wheel chair for supper between 5:15 p.m. and 5:30 p.m. earlier this evening. Both NA-A and NA-B stated R39 was to be repositioned every 2 hours. During interview on 10/27/15 at 8:43 p.m., the director of nursing and CM-A, stated that when they had interviewed NA-A and NA-B had placed R39 in his wheel chair before the evening meal at 5:25 p.m. and indicated they did not reposition resident while R39 was with family. R39 was assessed by the facility to need repositioning every 2 hours, however was not repositioned for 2 hours and 45 minutes. A policy regarding re-positioning of residents was requested, but none provided.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced	F 315		11/23/15

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	245410	A. BUILDING _____ B. WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICE CARE CENTER	1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201

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F 315	Continued From page 15 by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R39) with urinary incontinence was toileted according to the comprehensive assessment. Findings include: R39's admission minimum data set (MDS), dated 7/09/15, indicated R39 was moderately cognitively impaired, required extensive assistance with transferring and repositioning in bed and in wheelchair due to cerebral vascular accident (CVA) and was frequently incontinent of bladder. The care area assessment for Urinary Incontinence, dated 7/10/15, indicated: "resident has bladder [incontinence] [related to] [status post] [cerebral vascular accident]. He does not feel the sensation most of passing his urine most of the time. [Occasionally he will state he needs to void, and then will not. Rarely he will be accurate when he has asked for urinal. He has currently two remaining open moisture [related to] open area. Requires assist to manage his [incontinence] and bed mobility." The facility's policy, entitled: Bowel and Bladder Incontinence (last reviewed 01/15), indicated that all residents would be assessed upon admission and quarterly for incontinence, and that after the facility identified a voiding pattern would develop an individualized plan of care. The facility's most recent Elimination -- TENA/SCA Bladder Assessment (dated 10/07/15) for R39 indicated "not appropriate for Toileting or Retraining Program: - Check and Change with repositioning [and] use urinal as requested."	F 315	F 315 No Cather, Prevent UTI, Restore Bladder Corrective Action: Staff has been educated for resident 39 if he is with family staff need to interrupt the family time and check and change and reposition resident according to care plan. Corrective Action-identify other residents: All residents with urinary incontinence have been reviewed to insure accuracy of assessments & care plans and interventions are in place to improve or maintain urinary incontinence. Corrective Action to Prevent reoccurrence: Education to all nursing staff was completed on November 19, 2015. Education included the need for following the care plan for all residents including checking and changing &/or toileting. Monitoring for Compliance: DON or Designee will audit residents that need to be checked and changed with repositioning according to care plan. Audits will be done weekly for 4 weeks then twice a month for 1 month then monthly till stable. Results will be brought to QA committee for recommendation on the need to further audit.	

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F 315	Continued From page 16	F 315		

R39's care plan dated 7/2/15 identified "has incontinence of [bowel and bladder] - has [occasional] feeling of when he voids, but this is not consistent since CVA. He has no awareness of his [bowel movements." R39's care plan further indicated that R39 was to be "resident will be checked and changed with repositioning."

During observations on 10/27/2015 at 6:29 p.m., R39 was observed seated in his wheel chair, in the activity room and visiting with family following the evening meal. During continuous observation from 6:29 p.m. until 7:41 p.m., (one hour and 12 minutes) R39 remained in the activity area until 7:41 p.m., when R39, seated in the wheel chair, was returned to his room by family. R39 and family member visited in the room until 7:47 p.m., when R39's family member left, and activated R39's call light. At 7:49 p.m. nursing assistant (NA)-A answered R39's call light and went to retrieve more help for R39's evening cares. From 7:52 p.m. until 8:10 p.m. NA-A and NA-B provided evening cares, while R39 remained seated in his wheel chair. At 8:10 p.m., with use of the room lift, NA-A and NA-B placed R39 in bed. At 8:14 p.m., once on his bed and on R39's left side, NA-B removed a heavily saturated incontinent brief, reveling a reddened coccyx and bilateral inner buttocks fold. R39's skin, however, was intact. NA-B performed peri-care, applied a protective barrier cream, and reapplied a new brief.

During in interview at 8:29 p.m., NA-A and NA-B stated that it was not uncommon for R39 to be incontinent when R39 is checked. NA-B stated that R39 was last checked and changed when he was placed in his wheel chair for supper between 5:15 p.m. and 5:30 p.m. earlier this evening. Both

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 315	Continued From page 17 NA-A and NA-B stated R39 was to be checked and changed every 2 hours with his repositioned. During interview on 10/27/15 at 8:43 p.m., the director of nursing and CM-A, stated that when they had interviewed NA-A and NA-B had placed R39 in his wheel chair before the evening meal at 5:25 p.m. and indicated they did not check and change resident while R39 was with family. R39 was assessed by the facility to need to be checked and changed every 2 hours when repositioned, however was not repositioned for 2 hours and 45 minutes.	F 315		

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	245410	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/27/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICE CARE CENTER	**1801 SOUTHWEST WILLMAR AVENUE** **WILLMAR, MN 56201**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Rice Care Center - Building 01, was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The facility was inspected as two separate buildings: Rice Care Center - Building 01, is a 1-story building with no basement that was constructed at 6 different times. The original building was constructed in 1965 and was determined to be of Type II(111) construction. In 1995, an addition was constructed on the south side of the original building and was determined to be of Type II(111) construction. Since the original building and the 1995 addition are both Type II (111) construction they were both inspected as Building 01 under Existing Healthcare requirements. 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, and that is 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.	K 000	EPOC	

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

Electronically Signed | 11/24/2015

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/27/2015**

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K 000	Continued From page 1 The requirement at 42 CFR, Subpart 483.70(a) is MET as evidenced by:	K 000		

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	245410	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**10/27/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, the Rice Care Center - Building 03, additions were found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done	K 000	EPOC	

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

Electronically Signed | 11/24/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**10/27/2015**

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K 000	Continued From page 1 to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The facility was inspected as two separate buildings: The Rice Care Center - Building 03 consists of five separate additions that were constructed at four different times. The first addition was built in 2011, and is a 1-story addition without a basement that is located on the south side of Building - 01 and was determined to be of Type V(111) construction. The second addition was built in 2012, and is a 1-story addition without a basement that is located on the south side of the northeast wing of Building - 01 and was determined to be of Type V(111) construction. The third addition was built in 2013, and is a 1-story addition without a basement that is located on the south side of the northwest wing of Building - 01 and was determined to be of Type V(111) construction. The fourth addition to the facility consisted of two building that were both built in 2014, both additions are 1-story additions without basements that are located on the west side of Building - 01 and on the west side of the 2011 addition. It was determined that both 2014 additions are of Type V(111) construction. Since the five additions are all constructed of Type V(111) construction, they were inspected as one building labeled as Building - 03 and to New	K 000		

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	245410	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**10/27/2015**

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K 000	Continued From page 2 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.	K 000		
K 147 SS=C	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 the charting room by Therapy Services. This deficient practice was verified by Maintenance Supervisor (RW)	K 147	An electrician installed a 4-plex outlet to plug in refrigerator and freezer. It 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.	10/29/15

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MDH Minnesota Department of Health

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

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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00313	A. BUILDING: _____ B. WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICE CARE CENTER	1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On October 26-29th, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff followed the plan of care for 1 of 3 residents, (R39) identified at risk for pressure ulcers, who was not timely repositioned. In addition, the facility failed to ensure staff followed the plan of care for 1 of 3 residents (R39) reviewed who required assistance with toileting. Findings include: R39's admission minimum data set (MDS), dated 7/09/15, indicated R39 was moderately cognitively impaired, required extensive assistance with transferring and repositioning in bed and in wheelchair due to cerebral vascular accident (CVA) and was at risk for pressure ulcer (PU) development and urinary incontinence. The care area assessment for Pressure Ulcers, dated 7/10/15, indicated: "resident is at risk for skin breakdown [related to] requiring extensive	2 565		

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2 565	Continued From page 3 assistance with bed mobility, he has [frequent] incontinence of [bowel and bladder] and was admitted to the facility with open areas [related to] moisture on coccyx [and] peri area (scrotum)." The care area assessment for Urinary Incontinence, dated 7/10/15, indicated: "resident has bladder [incontinence] [related to] [status post] [cerebral vascular accident]. He does not feel the sensation most of passing his urine most of the time. [Occasionally he will state he needs to void, and then will not. Rarely he will be accurate when he has asked for urinal. He has currently two remaining open moisture [related to] open area. Requires assist to manage his [incontinence] and bed mobility." R39's care plan dated 7/2/15 identified "Is at risk for skin breakdown [related to] immobility, incontinence, and wearing of a splint. [History] of open areas under scrotum, coccyx and heel." R39's care plan further indicated that R39 was to be "turned [and] reposition every two hours. Is to have heel protector boots on at all times, expect during bathing/cares." R39's care plan further identified: "has incontinence of [bowel and bladder] - has [occasional] feeling of when he voids, but this is not consistent since CVA. He has no awareness of his [bowel movements." R39's care plan further indicated that R39 was to be "resident will be checked and changed with repositioning." During observations on 10/27/2015 at 6:29 p.m., R39 was observed seated in his wheel chair, in the activity room and visiting with family following the evening meal. During continuous observation from 6:29 p.m. until 7:41 p.m., (one hour and 12 minutes) R39 remained in the activity area until 7:41 p.m., when R39, seated in the wheel chair,	2 565		

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2 565	Continued From page 4 was returned to his room by family. R39 and family member visited in the room until 7:47 p.m., when R39's family member left, and activated R39's call light. At 7:49 p.m. nursing assistant (NA)-A answered R39's call light and went to retrieve more help for R39's evening cares. From 7:52 p.m. until 8:10 p.m. NA-A and NA-B provided evening cares, while R39 remained seated in his wheel chair. At 8:10 p.m., with use of the room lift, NA-A and NA-B placed R39 in bed. At 8:14 p.m., once on his bed and on R39's left side, NA-B removed a heavily saturated incontinent brief, reveling a reddened coccyx and bilateral inner buttocks fold. R39's skin, however, was intact. NA-B performed peri-care, applied a protective barrier cream, and reapplied a new brief. During in interview at 8:29 p.m., NA-A and NA-B stated that it was not uncommon for R39 to be reddened in the area noted during evening peri care. NA-B stated that R39 was last checked/changed and repositioned when he was placed in his wheel chair for supper between 5:15 p.m. and 5:30 p.m. earlier this evening. Both NA-A and NA-B stated R39 was to be repositioned and checked and changed for urinary incontinence every 2 hours. During interview on 10/27/15 at 8:43 p.m., the director of nursing and registered nurse (RN)-A, stated that when they had interviewed NA-A and NA-B, R39 was placed in his wheel chair "before the evening meal at 5:25 p.m." NA-A and NA-B also indicated R39 was not checked/changed or repositioned while R39's family was present. R39 was assessed by the facility to need repositioning and checked and changed for urinary incontinence every 2 hours, however was	2 565		

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2 565	Continued From page 5 not repositioned for 2 hours and 45 minutes. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to update care staff and develop a monitoring system to ensure staff are providing timely services as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by:	2 900		

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2 900	Continued From page 6 Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R39) with history of pressure ulcers, were provided care to prevent the development of new pressure ulcers. Findings include: R39's admission minimum data set (MDS), dated 7/09/15, indicated R39 was moderately cognitively impaired, required extensive assistance with transferring and repositioning in bed and in wheelchair due to cerebral vascular accident (CVA) and was at risk for pressure ulcer (PU) development. The care area assessment for Pressure Ulcers, dated 7/10/15, indicated: "resident is at risk for skin breakdown [related to] requiring extensive assistance with bed mobility, he has [frequent] incontinence of [bowel and bladder] and was admitted to the facility with open areas [related to] moisture on coccyx [and] peri area (scrotum)." The facility's most recent Skin Risk Assessment (dated 10/07/15) for R39 indicated this resident continued to be at moderate risk for skin breakdown. R39's Tissue Tolerance Testing RCC (Rice Care Center) - Sitting, dated 10/07/15 indicated that R39 was assessed for: "Two Hour Reposition Schedule - resident showed no signs of redness over bony prominence at the 2 hour assessment." R39's care plan dated 7/2/15 identified "Is at risk for skin breakdown [related to] immobility, incontinence, and wearing of a splint. [History] of open areas under scrotum, coccyx and heel." R39's care plan further indicated that R39 was to be "turned [and] reposition every two hours. Is to have heel protector boots on at all times, expect	2 900		

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2 900	Continued From page 7 during bathing / cares." During observations on 10/27/2015 at 6:29 p.m., R39 was observed seated in his wheel chair, in the activity room and visiting with family following the evening meal. During continuous observation from 6:29 p.m. until 7:41 p.m., (one hour and 12 minutes) R39 remained in the activity area until 7:41 p.m., when R39, seated in the wheel chair, was returned to his room by family. R39 and family member visited in the room until 7:47 p.m., when R39's family member left, and activated R39's call light. At 7:49 p.m. nursing assistant (NA)-A answered R39's call light and went to retrieve more help for R39's evening cares. From 7:52 p.m. until 8:10 p.m. NA-A and NA-B provided evening cares, while R39 remained seated in his wheel chair. At 8:10 p.m., with use of the room lift, NA-A and NA-B placed R39 in bed. At 8:14 p.m., once on his bed and on R39's left side, NA-B removed a heavily saturated incontinent brief, reveling a reddened coccyx and bilateral inner buttocks fold. R39's skin, however, was intact. NA-B performed peri-care, applied a protective barrier cream, and reapplied a new brief. During in interview at 8:29 p.m., NA-A and NA-B stated that it was not uncommon for R39 to be reddened in the area noted during evening peri care. NA-B stated that R39 was last repositioned when he was placed in his wheel chair for supper between 5:15 p.m. and 5:30 p.m. earlier this evening. Both NA-A and NA-B stated R39 was to be repositioned every 2 hours. During interview on 10/27/15 at 8:43 p.m., the director of nursing and CM-A, stated that when they had interviewed NA-A and NA-B had placed	2 900		

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2 900	Continued From page 8 R39 in his wheel chair before the evening meal at 5:25 p.m. and indicated they did not reposition resident while R39 was with family. R39 was assessed by the facility to need repositioning every 2 hours, however was not repositioned for 2 hours and 45 minutes. A policy regarding re-positioning of residents was requested, but none provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could identify and review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing, and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits to monitor nursing care to ensure appropriate and care-planned interventions are implemented and completed timely for residents at risk for pressure ulcers. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized	2 910		

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2 910	Continued From page 9 unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R39) with urinary incontinence was toileted according to the comprehensive assessment. Findings include: R39's admission minimum data set (MDS), dated 7/09/15, indicated R39 was moderately cognitively impaired, required extensive assistance with transferring and repositioning in bed and in wheelchair due to cerebral vascular accident (CVA) and was frequently incontinent of bladder. The care area assessment for Urinary Incontinence, dated 7/10/15, indicated: "resident has bladder [incontinence] [related to] [status post] [cerebral vascular accident]. He does not feel the sensation most of passing his urine most of the time. [Occasionally he will state he needs to void, and then will not. Rarely he will be accurate when he has asked for urinal. He has currently two remaining open moisture [related to] open area. Requires assist to manage his [incontinence] and bed mobility." The facility's policy, entitled: Bowel and Bladder Incontinence (last reviewed 01/15), indicated that all residents would be assessed upon admission	2 910		

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2 910	Continued From page 10 and quarterly for incontinence, and that after the facility identified a voiding pattern would develop an individualized plan of care. The facility's most recent Elimination -- TENA/SCA Bladder Assessment (dated 10/07/15) for R39 indicated "not appropriate for Toileting or Retraining Program: - Check and Change with repositioning [and] use urinal as requested." R39's care plan dated 7/2/15 identified "has incontinence of [bowel and bladder] - has [occasional] feeling of when he voids, but this is not consistent since CVA. He has no awareness of his [bowel movements." R39's care plan further indicated that R39 was to be "resident will be checked and changed with repositioning." During observations on 10/27/2015 at 6:29 p.m., R39 was observed seated in his wheel chair, in the activity room and visiting with family following the evening meal. During continuous observation from 6:29 p.m. until 7:41 p.m., (one hour and 12 minutes) R39 remained in the activity area until 7:41 p.m., when R39, seated in the wheel chair, was returned to his room by family. R39 and family member visited in the room until 7:47 p.m., when R39's family member left, and activated R39's call light. At 7:49 p.m. nursing assistant (NA)-A answered R39's call light and went to retrieve more help for R39's evening cares. From 7:52 p.m. until 8:10 p.m. NA-A and NA-B provided evening cares, while R39 remained seated in his wheel chair. At 8:10 p.m., with use of the room lift, NA-A and NA-B placed R39 in bed. At 8:14 p.m., once on his bed and on R39's left side, NA-B removed a heavily saturated incontinent brief, reveling a reddened coccyx and bilateral inner buttocks fold. R39's skin, however, was intact. NA-B performed peri-care, applied a	2 910		

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2 910	Continued From page 11 protective barrier cream, and reapplied a new brief. During in interview at 8:29 p.m., NA-A and NA-B stated that it was not uncommon for R39 to be incontinent when R39 is checked. NA-B stated that R39 was last checked and changed when he was placed in his wheel chair for supper between 5:15 p.m. and 5:30 p.m. earlier this evening. Both NA-A and NA-B stated R39 was to be checked and changed every 2 hours with his repositioned. During interview on 10/27/15 at 8:43 p.m., the director of nursing and CM-A, stated that when they had interviewed NA-A and NA-B had placed R39 in his wheel chair before the evening meal at 5:25 p.m. and indicated they did not check and change resident while R39 was with family. R39 was assessed by the facility to need to be checked and changed every 2 hours when repositioned, however was not repositioned for 2 hours and 45 minutes. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for urinary incontinence to assure they are receiving the necessary treatment/services to promote continence. The director of nursing or designee, could conduct random audits to ensure appropriate care and services are implemented to promote and maintain urinary continence. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		

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21565	Continued From page 12	21565		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that 1 of 1 residents (R11), with a self-administration of medication order, entirely consumed the medications after set up. Findings include: R11' physician order report, dated 9/16/15, listed the diagnoses of Alzheimer's dementia with delusions and disruptive behaviors. The Annual minimum data set (MDS), dated 8/11/15 indicated that R11 required extensive assistance with most activities of daily living, and also was severely, cognitively impaired. In review of the most recent signed physician's orders, dated 9/16/15, R11 had an order for Seroquel (anti-psychotic medication) 25 milligrams (mg) every P.M. at supper time - can mix in coffee. During observation on 10/27/2015 at 5:47 p.m., R11 was sitting at a table in the dining room in Cushman Cottage. R11 had been served the evening meal, which included 3 beverages (one glass of water, one glass of orange juice and one cup of coffee). In an interview at 5:52 p.m.,	21565		

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licensed practical nurse (LPN)-A stated she placed R11's Seroquel in her orange juice. At 6:01 p.m., R11 placed her napkin on her table, pushed her way from her table and wheeled herself to the dayroom down the hall to watch "Wheel of Fortune." There remained approximately 1/2-1 ounce of orange juice in R11's cup. Two other residents, who ate with R11, remained at the table eating their meals.

At 6:10 p.m. LPN-A returned to the dining room, when the surveyor asked about the medicated orange juice left in the cup by R11. LPN-A was unaware that R11 had not finished the orange juice, which contained the Seroquel medication, and after grabbing the glass, took it to the dayroom where R11 sat watching TV and had R11 finish taking her medication.

R11's care plan indicated that R11 had Alzheimer's, with severe dementia with behaviors, paranoia, auditory hallucinations, and both short and long term memory loss. The care plan further indicated, as an approach, that R11 needed assistance with medication administration due to poor vision, and her refusal to take [medication]. The approach directed that both R11's Miralax (powder laxative) and Seroquel be mixed in coffee so that she would take it.

During interview on 10/29/2015 9:15 a.m., registered nurse (RN)-A stated R11 needed Seroquel for maintaining her ability to be involved in her environment, and also due to R11's behaviors associated with paranoia and auditory hallucinations. RN-A stated that R11 will only take medications in the morning due to one of her prior auditory hallucinations, and R11's physician felt the single dose of Seroquel was more beneficial for R11 in the evening. RN-A said staff

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21565	Continued From page 14 need to make sure, that when mixing medications in food and/or beverages, that medications were consumed totally. A self administration of medication assessment for R11 was requested from the facility, but RN-A indicated none had been completed. A facility Policy entitled Self Administration of Medication, last revised 12/06, did not include provision for residents, who were cognitively impaired, and how they would be assessed and monitored for compliance, when medications are placed in their food and fluids. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or desigee could educate staff on appropriate assessment of and instruction to residents regarding self-administration of medication. The DON or designee could randomly audit medication pass to ensure resident and staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure safe water temperatures were maintained in 2 of 12 resident	21665		

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21665	Continued From page 15 rooms in 1 of 3 households in the facility. Findings include: During observation on 10/26/2015 between 2:30 p.m. and 5:00 p.m., the following water temperatures were noted: Room 105 was 120 degrees F (Fahrenheit); and room 109 was 120 degrees F. During a revisit to the rooms at 5:15 p.m., a facility maintenance worker (MW) -A observed these hot water temperatures: Room 105 was 120.1, and room 109 was 120.7. A review of facility incident reports from 11/1/2014 to 10/26/2015 indicated there were no residents who sustained burns or who had incidents related to use of hot water in the facility. During an interview on 10/26/2015 at 5:30 p.m., the director of nursing confirmed there had been no burn-related incidents in the facility during this time frame regarding hot water temperatures. In an interview on 10/29/2015 at 10:25 a.m., MW-B said water temperatures in randomly selected rooms were checked every week, "but that practice was discontinued after January 24th" [of this year]. MW-B stated now water temperature gages "were checked daily on our maintenance rounds," and further, individual rooms "would be tested" if there were concerns of the water being too hot. MW-B said there were two sources for hot water in the building, one heater serving the new Therapy Suites area, and the other was for the older parts of the building, for Sophia House and Cushman Cottage. MW-B stated that the "set point" to regulate the hot water temperature in the Therapy Suites "was lowered to 110 degrees" on Monday this week. MW-B said the set point of 110 degrees	21665		

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maintains the water temperatures "plus or minus 5 degrees," to stay in the "105 to 115 range." MW-B said before Monday, the set point "was at 118 degrees," and the temps would have ranged from about 113 to 123 degrees. MW-B stated the set point at the mixing valve, regulating the hot water in the "older part" of the building, was "always set" at 110 degrees. MW-B said hot water in resident rooms should be "between 105 and 115 degrees."

On 10/29/2015 between 9:45 and 10:00 a.m., in the presence of the surveyor, MW-B took water temperatures from a sample of rooms closest to and farthest from the hot water sources on each of the three facility wings, as well as in common resident bathing rooms. During this time, the water temperatures ranged from 107.0 to 112.5 degrees F.

Domestic Water temperature logs from 7/1/2015 to 10/29/15 were reviewed. Logged temperatures in Therapy Suites ranged between 110 and 124 degrees F. Temperatures in the Long Term Care [Sophia House and Cushman Cottage] ranged between 110 and 123 degrees F.

In an interview on 10/29/2015 at 11:05 a.m., the administrator said maintenance was responsible to monitor water temperatures in resident rooms. The administrator stated "I would expect follow through" regarding checks of the water, and that maintenance "report to me any areas of concern" so that decisions could be made regarding the building and its operations.

A facility policy, RCC Hot Water Temps, undated, directed "To maintain a safe facility, the hot water temps [temperatures] will be tested every other week to assure resident safety and that water

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21665	Continued From page 17 temps are kept within the safe range of 105 degrees to 115 degrees [Fahrenheit]." An update water policy was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.	21850		

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21850	Continued From page 18 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to report allegations of abuse immediately to the state agency for 1 of 3 residents (R3) allegations reviewed. Findings include: R3's quarterly Minimum Data Set, MDS dated 9/29/15, indicated she was cognitively intact and required assist of one to two staff for activities of daily living. R3's care plan dated 9/29/15 identified R3 as a "vulnerable adult," however, it did not address areas of vulnerability, nor any interventions to protect R3 from abuse. During an interview on 10/27/15, at 12:56 p.m., R3 reported two staff members in the facility had abused her. When asked which staff, R3 replied, "ummm, some of the aides I've had problems with,they treat me quite rudely, and are rough when handling me." R3 stated there was one (aide) on the day shift, and one on the evening shift. R3 stated she spoke to the nurse manager about one of them, and "the girl denied it." R3 further stated the treatment by that staff member had not improved, and so R3 stated she "did not report the other staff member" due to lack of result from the first complaint. R3 further also said, "I don't like it, I would call that abuse when they are so mean to me." The surveyor reported R3's allegation of abuse to the facility administrator on 10/27/15, at 3:19 p.m. Review of R3's Progress Note dated 10/27/15 indicated, "It was brought to this writer's attention that resident had a concern regarding a staff	21850		

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member abusing her. This writer and DON [director of nursing] visited with resident regarding this concern. Resident initially denied any concerns. When asked again, she stated, 'It is when [staff] provides my cares.' [R3] stated that, 'I talked to you about her before, but you did not do anything about it.' This writer reminded resident that it was previously discussed that [the staff member] will not discuss her personal life with resident. Resident stated she felt offended by this. Writer had previously discussed this with [the staff member] who stated that she felt uncomfortable discussing her personal life with resident. Resident then stated [the staff member] is rude to resident -i.e.- she does not talk to resident much. She throws resident's clothes across the room and/or shoes in the closet. She swings lift across the room. She refuses to wash resident's bottom in the shower. She does not put the lift sheet under the resident comfortably. This writer and DON have both heard resident request for this staff member to provide her cares in the past. However, resident denies that this has ever happened. Resident stated that she felt stressed when the staff member was in providing her care. This writer informed resident that she would talk with the staff member about these concerns and suggested that this writer observe staff providing cares for resident. Resident refused, stating this is not necessary. Resident stated, 'I knew I should not have said anything.' This writer explained to her that it is important that she feel safe and comfortable here, and that she need to feel okay with the staff that care for her."

During and interview on 10/28/15, at 1:02 p.m., registered nurse (RN)-A stated, "It was brought to my attention by the administrator that R3 had a complaint." RN-A stated R3 had not reported an instance of abuse to her previously. She spoke

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with R3 who initially denied the accusations and then told her about concerns with the staff member. RN-A stated, R3 "Will often try to get information about staff and share the information with others inaccurately." RN-A further stated she offered to have other staff provide care for R3 and offered to observe cares with staff and R3 and that two staff go into the room with R3 because "This is what she does."

During an interview on 10/28/15, at 8:46 a.m., R3 stated that she was aware of how to report instances of abuse both in the facility and to the outside agencies but declined any further questions regarding her previous allegations.

During an interview on 10/29/15, at 8:46 a.m., the director of nursing (DON) stated the allegations made by R3 were not reported to the state agency. The DON further stated she was in the room when RN-A spoke with R3, and stated, R3 never said she was abused by the staff, only that [R3] didn't like the staff member. The DON stated, "I didn't feel there was any abuse."

Although, the facility was aware of R3's allegation of being mistreated, the facility did not immediately report the incident to the State Agency, but instead began to investigate R3's allegation.

A facility policy, Vulnerable Adult Abuse Prevention, Rice Care Center, dated 7/2015, indicated its purpose was "to protect residents from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of their property." The policy directed staff to immediately report any suspected abuse to the facility administrator and to the state agency.

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21850	Continued From page 21 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to abuse and abuse prohibition. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21850		