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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 54BM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00470

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245251**
2.STATE VENDOR OR MEDICAID NO.
(L2) **861347800**

3. NAME AND ADDRESS OF FACILITY
(L3) **RIVERVIEW HOSPITAL & NURSING HOME**
(L4) **323 SOUTH MINNESOTA**
(L5) **CROOKSTON, MN** (L6) **56716**

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 **01/24/2017** (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 **24** (L18)
13.Total Certified Beds **24** (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
	24			
(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 :
Lyla Burkman, Unit Supervisor — 03/20/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 04/07/2017 (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
08/01/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/31/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245251

April 6, 2017

Mr. Paul Gaebe - Interim, Administrator
Riverview Hospital & Nursing Home
323 South Minnesota
Crookston, Minnesota 56716

Dear Mr. Gaebe - Interim:

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

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

Effective January 2, 2017, the above facility is certified for:

24 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 24 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 20, 2017

Mr. Paul Gaebe - Interim, Administrator
Riverview Hospital & Nursing Home
323 South Minnesota
Crookston, Minnesota 56716

RE: Project Number S5251038

Dear Mr. Gaebe - Interim:

On December 23, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standa survey, completed on December 8, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On January 24, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 6, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 8, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 2, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 8, 2016, effective January 2, 2017 and therefore remedies outlined in our letter to you dated December 23, 2016, will not be imposed.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245251 Y1	A. Building B. Wing Y2	1/24/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0280	Correction	ID Prefix F0282	Correction	ID Prefix F0314	Correction
Reg. # 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)	Completed	Reg. # 483.21(b)(3)(ii)	Completed	Reg. # 483.25(b)(1)	Completed
LSC	12/30/2016	LSC	01/01/2017	LSC	12/30/2016
ID Prefix F0315	Correction	ID Prefix F0323	Correction	ID Prefix F0329	Correction
Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.25(d)(1)(2)(n)(1)-(3)	Completed	Reg. # 483.45(d)	Completed
LSC	12/30/2016	LSC	12/30/2016	LSC	12/30/2016
ID Prefix F0428	Correction	ID Prefix F0441	Correction	ID Prefix	Correction
Reg. # 483.45(c)(1)(3)-(5)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	12/31/2016	LSC	01/02/2017	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	LB/MM	02/07/2017	28035	01/24/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/8/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245251 (Y1)	A. Building 01 - NURSING HOME 01 B. Wing (Y2)	1/6/2017 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0345	Correction Completed 12/28/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR / TITLE	DATE
STATE AGENCY [X]	TL/MM	02/07/2017	36536	01/06/2017
CMS RO [ ]			TITLE	

FOLLOWUP TO SURVEY COMPLETED ON	
12/6/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 54BM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00470

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245251**
2.STATE VENDOR OR MEDICAID NO.
(L2) **861347800**

3. NAME AND ADDRESS OF FACILITY
(L3) **RIVERVIEW HOSPITAL & NURSING HOME**
(L4) **323 SOUTH MINNESOTA**
(L5) **CROOKSTON, MN** (L6) **56716**

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 **12/08/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **24** (L18)
13.Total Certified Beds **24** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	24			
(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 :
Debra Vincent, HFE NEII
01/06/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/30/2017 (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
08/01/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 23, 2016

Mr. Paul Gaebe - Interim Administrator
Riverview Hospital & Nursing Home
323 South Minnesota
Crookston, Minnesota 56716

RE: Project Number S5251038

Dear Mr. Gaebe - Interim:

On December 8, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 17, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 17, 2017 the following remedy will be imposed:

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

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.

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 March 8, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 8, 2017 (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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

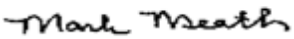
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

(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 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the	F 280		12/30/16

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

Electronically Signed | 01/02/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	12/08/2016

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F 280	Continued From page 1 right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 280		

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F 280	Continued From page 2 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to revise the care plan to include individualized target behaviors for the use of antipsychotic medication for 1 of of 5 residents (R21) reviewed for unnecessary medications. Finding include: R21's Physician Order Report dated 11/7/16 - 12/7/16, indicated R21 had medication orders that included quetiapine (Seroquel) (antipsychotic) 12.5 mg at bedtime for delusional disorder, and Celexa (citalopram) (antidepressant) 20 mg once a morning for depressive episodes. R21's undated Care Plan identified R21 received antipsychotic medication related to Alzheimer's dementia, delirium exhibited while in the hospital, and sundowning and received the antidepressant	F 280	Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions, or an agreement, that a deficiency exists or that the statement of a deficiency was correctly cited or factually based and it is not to be construed as an admission against the interest of the facility, the administrator, or any employees, agents, or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same. The care Plan for R21 was reviewed by Director of Nursing on 12/12/16. Care plan was then updated to include specific target behaviors to address residents individualized needs. Written update was	

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F 280	Continued From page 3 Celexa (started 1/30/16) with a goal R21 would be prescribed the lowest effective dose of medication. The Care Plan directed staff to administer medications Seroquel and Celexa, monitor resident's behavior and response to medication, document resident behavior and approaches tried, implement a behavior management plan as needed, attempt non-pharmacological approaches such as 1:1, redirect, folding clothes, walk, movie, game, coffee, food or snack and pharmacy consultant review. The Care Plan lacked individualized target behaviors for the use of Seroquel. On 12/8/16, at 8:54 a.m. the director of nursing (DON) confirmed R21's care plan did not include individualized target behaviors for the use of Seroquel. The Behavior Monitoring Policy dated 11/16, indicated residents who received a behavior altering drug and/or exhibited negative behaviors would have target behaviors documented every shift. The problem behaviors would also be documented in the resident's plan of care. The policy also indicated this information was updated with any change in behavior, staff approach, resident's ability to be redirected and the addition or discontinuation of a psychotropic medication.	F 280	provided in communication book on 12/13/16 for all staff to review. 12/12/16-12/13/16 all care plans were reviewed and target behaviors were identified for all residents. As of 12/30/16 all residents will have target behaviors identified on admission and included into the written plan of care. Residents care plan will be reviewed at least quarterly and updated as needed. Random audits will be performed by DON or delegate to assure proper compliance of target behavior identification. Audits will be completed monthly for 6 months of consecutive compliance. Additional audits will be performed if deemed necessary by interdisciplinary team (IDT). Audit finding will be discussed at weekly IDT meetings as well as quarterly QA meetings.	
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in	F 282		1/1/17

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F 282	Continued From page 4 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide repositioning for 1 of 1 (R10) resident observed for positioning/toileting. In addition, the facility failed to ensure behavior monitoring was completed for 2 of 2 clients (R5, R13) reviewed for unnecessary medications. R10's Care Plan revised 9/22/16, indicated R10 required extensive assistance of two staff with bed mobility, transfers and toileting. The care plan indicated R10 had functional incontinence and was always incontinent. The care plan directed staff to check and change R10's brief every two hours. The current nursing assistant (NA)group assignment sheet indicated all residents were to be toileted every 2-3 hours unless otherwise stated. On 12/7/16, at 7:20 a.m. R10 was observed to be in bed fully dressed, NA-B stated at that time she had to find someone to help her transfer R10 to the Geri-chair with the Hoyer lift. At 7:29 a.m. NA-B and NA-A were observed to transfer R10 from the bed with a Hoyer lift to the Geri-chair. R10 was wheeled to the dining room for breakfast. On 12/7/16, at 11:15 p.m. NA-A was observed to wheel R10 who was sitting in the geri-chair into R10's room. NA-A stated R10 had been in the chair since before breakfast and had not been repositioned or checked for incontinence since	F 282	12/7/16 DON was notified of occurrence of extended length between incontinence cares for R10 and care plan not being followed. Resident skin was assessed by DON and found to have no evidence of breakdown as skin was pink and blanchable. Education was provided on 12/7/16 to all staff working and written education was provided in communication book for all staff to review. 12/8/16 DON was notified of inadequate behavior documentation for R5 and R13. On 12/30/16 Individualized behavior sheets were implemented for R5 and R13 to allow for quantitative documentation on target behaviors. 12/12/16-12/13/16 all care plans were reviewed to assure incontinence and repositioning needs were identified. Individualized behavior monitoring sheets were implemented facility wide on 1/1/17 to allow individualized behavior documentation to occur. Education provided at staff meeting on 12/12/16 regarding care plan compliance and updates to the behavior documentation sheets. All residents are assessed on admission, annually, and as needed per Bowel and bladder assessment and tissue tolerance test for need of incontinence care and repositioning needs. Residents□ bowel and bladder continence level is updated	

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F 282	Continued From page 5 R10 was assisted out of bed. At that time NA-A and NA-C transferred R10 to the bed and provided incontinence care. R10 was observed to be incontinent of urine. R10's skin was intact but the buttock area had red imprints from the brief and the right thigh area had a bright red mark from the elastic on the disposable brief. NA-A stated normally R10 is assisted back to bed right after breakfast but activity staff had requested R10 attend an activity program. NA-A confirmed R10 had been up in the chair without repositioning/toileting for three hours and forty-five minutes. On 12/7/16 at 12:50 p.m. NA-B verified R10 was not repositioned or checked for incontinence for over 3 hours. NA-B stated they took R10 to activities. On 12/7/16, at 2:15 p.m. the director of nursing (DON)stated R10's plan of care directed staff to provide toileting or incontinence care every two hours. The DON verified she expected staff to follow the resident care plan. The DON added staff could have provided incontinence care and then taken R10 to activities. The Care Plan policy, reviewed on 11/16, indicated each resident will have a care plan evaluated and revised as necessary to reflect the resident's current status. The policy indicated the plan of care would be developed by using individual resident assessment data and resident's expectation and customary routine. The policy indicated qualified individuals would implement identified interventions/approaches in the Care Plan. R5 received antipsychotic (Seroquel) and antianxiety (Alprazolam) medications. The clinical	F 282	on care plan to reflect their individual needs. As of 12/30/16 all residents will have target behaviors identified on admission and included into the written plan of care. These individualized behaviors will then be documented on q shift by staff. Random audits will be performed by DON or designee to assure proper care plan compliance regarding repositioning and incontinence care, as well as documentation of specific target behaviors. Audits will be completed 14 times in first 30 days. Additional audits will be performed if deemed necessary by IDT. Audit finding will be discussed at weekly IDT meetings as well as quarterly QA meetings.	

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F 282	Continued From page 6	F 282		

record lacked monitoring of individualized target behaviors.
R5's Physician Order Report dated 11/7/16-12/7/16, indicated R5 had diagnoses of psychosis (lack of contact with reality), and anxiety. The report further identified the prescribed medications of alprazolam (antianxiety medication) and Seroquel (antipsychotic medication).
R5's Care Plan dated 12/5/16, indicated R5 received antipsychotic and antianxiety medications, exhibited behaviors of irritability, anxiety, swearing, slamming walker against the wall/floor and paranoia of others stealing her items. The care plan further directed staff to quantitatively and objectively document the resident's behaviors.
R5's clinical record lacked evidence of quantitatively and objectively documenting R5's behaviors.
R13 received antipsychotic (Seroquel) and antianxiety (Alprazolam) medications. The clinical record lacked monitoring of individualized target behaviors.
R13's Physician Order Report dated 11/7/16-12/7/16, indicated R13 had diagnoses of psychosis (lack of contact with reality), and agitation. The report further identified physician orders for the medications of Alprazolam (antianxiety) and quetiapine (Seroquel) (antipsychotic medication).
R13's Care Plan dated 11/7/16, indicated R13 received antipsychotic and antianxiety medications, exhibited behaviors of hallucination, agitation, paranoia and anxiety. The care plan further directed staff to quantitatively and objectively document the resident's behaviors.
R13's clinical record lacked evidence of quantitatively and objectively documenting R5's

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F 282	Continued From page 7 behaviors. On 12/8/16, at 9:00 a.m. the director of nursing (DON) verified specific target behaviors for R5 and R13 were not being monitored as directed by the care plan.	F 282		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely repositioning was provided for 1 of 2 residents (R10) who were at risk for developing a pressure ulcer and required every two hour repositioning assistance. Findings include: R10 was not provided repositioning on 12/7/16 from 7:30 a.m. until 11:15 a.m. (three hours and	F 314	12/7/16 DON was notified of occurrence of extended length between repositioning for R10. Resident skin was assessed by DON and found to have no evidence of breakdown as skin was pink and blanchable. R10 care plan and care sheet updated on 12/12/16 to reflect need for repositioning q 2hrs. Education was provided on 12/7/16 to all staff working and written education was provided in communication book for all staff to review.	12/30/16

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F 314	Continued From page 8 forty-five minutes). R10's change of status Minimum Data Set (MDS) dated 10/30/16, indicated R10 had severe cognitive impairment and diagnoses which included Alzheimer's disease, dementia, and anxiety. The MDS also indicated R10 required extensive assist of two people for bed mobility, transfer, dressing, toilet use and personal hygiene. The MDS further indicated R10 was at risk for the development of pressure ulcers. R10's Pressure Ulcer Care Area Assessment (CAA) dated 10/30/16, indicated R10 was at risk for pressure ulcers due to incontinence, cognitive loss and immobility. The CAA also indicated R10 was totally dependent on staff for bed mobility and required a Hoyer (mechanical) Lift for all mobility and also required a regular schedule of turning. R10's Braden Scale for predicting pressure sore risk dated 10/24/16, indicated R10 was at high risk for developing pressure sores. R10's Tissue Tolerance Assessment (observation to determine positioning schedule) dated 10/28/16, indicated R10 was on an every two hour repositioning schedule and showed no signs of redness over bony prominences at the two hour assessment. R10's Care Plan revised 9/22/16, indicated R10 required extensive assistance of two staff with bed mobility, transfers and toileting. The plan directed staff to use Hoyer lift at all times. The plan of care also directed staff to check and change R10's brief every two hours. The plan of care did not identify R10's repositioning needs. The current nursing assistant (NA) group	F 314	12/12/16-12/13/16 all care plans were reviewed to assure repositioning needs were identified. Education provided at staff meeting on 12/12/16 regarding Proper repositioning. All residents are assessed on admission, annually, and as needed per tissue tolerance testing for repositioning needs. Random observational audits will be performed on all shifts by DON or designee to assure proper repositioning of residents. Audits will be completed 4x/wk for one month, then decreased to 2x/wk for one month, followed by 1x/wk for one month. Additional audits will be performed if deemed necessary by IDT. Audit finding will be discussed at weekly IDT meetings as well as quarterly QA meetings.	

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F 314	Continued From page 9	F 314		

assignment sheet did not indicate how often R10's was to be repositioned, however, the assignment sheet indicated all residents were to be toileted every 2-3 hours unless otherwise stated.

On 12/7/16, at 7:20 a.m. R10 was observed to be in bed fully dressed. NA-B stated morning cares had just been completed and she had to find someone to help transfer R10 to the Geri-chair with the Hoyer lift. At 7:29 a.m. NA-B and NA-A were observed to transfer R10 from the bed with a Hoyer lift to the Geri-chair. R10 was wheeled to the dining room for breakfast.

On 12/7/16 at 11:15 p.m. NA-A was observed to wheel R10 in the Geri-chair into R10's room. NA-A stated R10 had been up in the chair since before breakfast. R10 had not been repositioned or checked for incontinence since R10 was assisted out of bed before breakfast. At that time NA-A and NA-C transferred R10 with the Hoyer lift to the bed and provided incontinence care. R10 was observed to be incontinent of urine. R10's skin was intact. The buttock area had red imprints from the brief and the right thigh area had a bright red mark from the elastic on the disposable brief. NA-A stated normally R10 was assisted back to bed right after breakfast but activity staff had requested R10 attend an activity program. NA-A confirmed R10 had been up in the chair without repositioning for three hours and forty-five minutes.

On 12/7/16 at 12:50 p.m. NA-B verified R10 was not repositioned for over 3 hours and stated R10 was taken by activity staff to attend a morning program.

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F 314	Continued From page 10 On 12/7/16, at 2:15 p.m. the director of nursing (DON) stated R10's plan of care was to be repositioned and toileted every two hours. The DON verified she expected staff to follow the resident care plan. The DON added if resident's do go back to bed right after breakfast then they miss out on activities. The Repositioning, toileting, exercise policy reviewed 11/16, indicated resident's dependent on staff and/or requiring staff assistance will be repositioned, toileted every 2-3 hours unless otherwise indicated by their comprehensive assessment. Each resident will have a comprehensive assessment, analysis of assessment and a plan of care to determine appropriate time frames for their need to be moved, provided with exercise and toileting assistance. The policy indicated specific information necessary to provide individualized care will be provided in the care plan and on the NA care sheets with changes communicated in each shift report.	F 314		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 315		12/30/16

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F 315	Continued From page 11 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely repositioning was provided for 1 of 2 residents (R10) who were at risk for developing a pressure ulcer and required every two hour repositioning assistance. Findings include: R10 was not provided repositioning on 12/7/16 from 7:30 a.m. until 11:15 a.m. (three hours and forty-five minutes).	F 315	-12/7/16 DON was notified of occurrence of extended length between incontinence cares for R10 Resident skin was assessed by DON and found to have no evidence of breakdown as skin was pink and blanchable. Education was provided on 12/7/16 to all staff working and written education was provided in communication book for all staff to review. 12/12/16-12/13/16 all care plans were reviewed to assure incontinence needs were identified. Education provided at staff meeting on 12/12/16 regarding	

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F 315	Continued From page 12 R10's change of status Minimum Data Set (MDS) dated 10/30/16, indicated R10 had severe cognitive impairment and diagnoses which included Alzheimer's disease, dementia, and anxiety. The MDS also indicated R10 required extensive assist of two people for bed mobility, transfer, dressing, toilet use and personal hygiene. The MDS further indicated R10 was at risk for the development of pressure ulcers. R10's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 10/30/16, indicated R10 was always incontinent and totally dependent on staff for assistance. The CAA indicated R10 had functional incontinence due to physical and mental impairments and wore a brief that was changed by total assist of two staff with a Hoyer lift. R10's Care Plan revised 9/22/16, indicated R10 required extensive assistance of two staff with bed mobility, transfers and toileting. The plan of care directed staff to check and change R10 ' s brief every two hours. The current nursing assistant (NA) group assignment sheet indicated all residents were to be toileted every 2-3 hours unless otherwise stated. On 12/7/16, at 7:20 a.m. R10 was observed to be in bed fully dressed. NA-B stated morning cares had just been completed and she had to find someone to help transfer R10 to the Geri-chair with the Hoyer lift. At 7:29 a.m. NA-B and NA-A were observed to transfer R10 from the bed with a Hoyer lift to the Geri-chair. R10 was wheeled to the dining room for breakfast.	F 315	Proper incontinence care All residents are assessed on admission, annually, and as needed per Bowel and bladder assessment for need of incontinence care. Residents□ bowel and bladder continence level is updated on care plan to reflect their individual needs. Random observational audits will be performed on all shifts by DON or designee to assure proper care plan compliance regarding incontinence care. Audits will be completed 4x/wk for one month, then decreased to 2x/wk for one month, followed by 1x/wk for one month. Additional audits will be performed if deemed necessary by IDT. Audit finding will be discussed at weekly IDT meetings as well as quarterly QA meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 315	Continued From page 13	F 315		

On 12/7/16 at 11:15 p.m. NA-A was observed to wheel R10 in the Geri-chair into R10's room. NA-A stated R10 had been up in the chair since before breakfast. R10 had not been repositioned or checked for incontinence since R10 was assisted out of bed before breakfast. At that time NA-A and NA-C transferred R10 with the Hoyer lift to the bed and provided incontinence care. R10 was observed to be incontinent of urine. R10's skin was intact. The buttock area had red imprints from the brief and the right thigh area had a bright red mark from the elastic on the disposable brief. NA-A stated normally R10 was assisted back to bed right after breakfast but activity staff had requested R10 attend an activity program. NA-A confirmed R10 had been up in the chair without repositioning for three hours and forty-five minutes.

On 12/7/16 at 12:50 p.m. NA-B verified R10 was not repositioned for over 3 hours and stated R10 was taken by activity staff to attend a morning program.

On 12/7/16, at 2:15 p.m. the director of nursing (DON) stated R10's plan of care was to be repositioned and toileted every two hours. The DON verified she expected staff to follow the resident care plan. The DON added if resident's do go back to bed right after breakfast then they miss out on activities.

The Repositioning, toileting, exercise policy reviewed 11/16, indicated resident's dependent on staff and/or requiring staff assistance will be repositioned, toileted every 2-3 hours unless otherwise indicated by their comprehensive assessment. Each resident will have a comprehensive assessment, analysis of

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F 315	Continued From page 14 assessment and a plan of care to determine appropriate time frames for their need to be moved, provided with exercise and toileting assistance. The policy indicated specific information necessary to provide individualized care will be provided in the care plan and on the NA care sheets with changes communicated in each shift report.	F 315		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:	F 323		12/30/16

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 323	Continued From page 15 Based on observation, interview, and document review, the facility failed to complete a comprehensive falls assessment which included root cause analysis, to evaluate care plan interventions for efficacy for 1 of 3 residents (R25) reviewed for falls. Findings included: R25's Diagnosis Report dated 10/19/16, identified diagnoses which included Alzheimer's disease and abnormal weight loss. The physician order's identified an order was received on 10/19/16, to admit R25 to the facility. R25's admission Minimum Data Set (MDS) dated 10/27/16, indicated R25 had severe cognitive impairment, required supervision (oversight, encouragement or cueing) of one staff for walking in room, bed mobility and transferring. The MDS indicated R25 required supervision and set up help only when walking in the hallway, extensive assistance of one staff for dressing and limited assistance with toileting. The MDS also indicated R25 was not steady but able to stabilize herself without human assistance when moving from a sit to stand position or when turning around. R25's Fall Care Area Assessment (CAA) dated 10/28/16, indicated R25 had fallen before admission and had impaired balance. The CAA identified R25's internal risk factors for falling as incontinence, hearing impairment, cognitive impairment, and Alzheimer's disease. The CAA indicated R25 had fallen at home on the day of admission and was evaluated at the emergency department with no injuries noted. The assessment indicated R25 walked with a wheeled walker, gait appeared steady and one staff to	F 323	R25 care plan was reviewed by DON and updated 12/26/16 to include individualized fall interventions. All residents are evaluated on admission for potential fall risk by charge RN. In accordance with RAI guidelines and facility policy, they are also evaluated quarterly and with any significant changes. Res fall interventions are currently discussed at IDT meeting and interventions are documented in the IDT minutes for every fall. Education was provided at staff meeting on 12/12/16 on the facility's updated fall policy. Staff discussed the significance of the post fall huddle and the importance of including all of the staff that are present at time of the fall. The post fall huddle is when staff will discuss why a fall occurred and what can be done to prevent it from happening again. These interventions are then documented in the post fall observation and submitted to the DON. Physical changes have been made that will better aid in staff follow up and completion of post fall observations. Effective 12/30/16 proper fall interventions will be implemented after every fall to prevent the recurrence of falls. Resident falls and interventions will be reviewed at weekly IDT meetings with detailed notes detailing conversations surrounding fall interventions. Falls are then closed by DON, with the recommendations given by the IDT as well, in order to assure proper fall interventions are in place. Effective 12/30/16 all falls reports will be reviewed	

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F 323	Continued From page 16 supervise for ambulation. A falls risk assessment completed 10/24/16, indicated R25 had a score of 9 (10 or higher represents a high risk for falls). A therapy admission screen by a physical therapist (PT) dated 10/20/16, identified R25's fall before admission. The screening note indicated there were no reports of unsteadiness or loss of balance in the last 24 hours. The PT noted R25 ambulated with a front wheeled walker (FWW) and used safe technique getting in and out of chairs and is independent in toileting and self-cares. The PT noted no skilled therapy services were indicated and nursing to continue to monitor R25 for safety due to fall history. R25's care plan dated 10/24/16, indicated R25 was at risk for falling due to balance at times and previous falls at home. The interventions all dated 10/24/16, included give verbal reminders not to ambulate/transfer without assistance, keep call light in reach at all times, obtain PT consult for strength training, toning, positioning, transfer training, gait training and mobility devices. The care plan also indicated staff was to provide an environment free of clutter. The care plan identified R25 as being incontinent of bowel and bladder and directed staff to toilet R25 every 2-3 hours. The Residents Progress Notes (PN) written on 11/4/16, at 11:36 p.m. by a licensed practical nurse (LPN) noted resident was yelling out for help. Staff entered room and observed R25 sitting on the floor in front of the bed. R25 stated when coming back from the bathroom she fell onto the floor attempting to get into bed. No injury noted	F 323	by charge nurse and then submitted to DON within 24 hours to assure they are being completed properly and necessary information is included. Resident falls and interventions will be reviewed and conversation documented at weekly IDT meetings. Falls are also tracked and reported upon at quarterly QA meetings. Audits on documentation will be conducted by administrator or designee to assure proper compliance for fall follow-up and intervention implementation. Illness tracking audits will be completed 4x/wk for one month, then decreased to 2x/wk for one month, followed by 1x/wk for one month. Additional audits will be performed if deemed necessary by interdisciplinary team (IDT). Audit finding will be discussed at weekly IDT meetings as well as quarterly QA meetings.	

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F 323	Continued From page 17	F 323		

and neurological tests (neuro checks) were initiated and within normal limits (WNL). R25 was instructed on call light use. The post falls assessment completed by a LPN on 11/4/16, indicated R25 had a history of two falls in the last 90 days with no injuries. The current interventions identified were call light and PT consult. A measure taken to prevent further falls was to assist with toileting through out the night every two hours. The care plan and nursing care sheets were not updated.

A PN written by LPN on 11/10/16, noted during 4 am rounds staff observed R25 sitting on her buttocks on the floor in her room. The room was dark, the bathroom light was on and the bathroom door was shut. R25 stated she went to the bathroom and fell on the floor trying to get into bed. The resident denied pain and had full range of motion. The PN indicated R25 had a bruise on the arm from a previous fall. Neuro checks were initiated. Post fall assessment dated 11/10/16, by LPN indicated R25 had a a history of 3 falls in the last 90 days with no injuries. The current interventions identified were to check R25 through-out the night during rounds. The assessment noted the factor contributing to falls was the room was dark due to resident closing the bathroom door when leaving the bathroom. The assessment indicated the measures taken to prevent further falls were to leave the overhead light and bathroom light on at all times while resident is in room and continue with routine checks. The care plan and nursing care sheets were not updated.

The PN from 11/16/16, at 6:30 p.m. by a registered nurse (RN) noted staff heard R25 hollering, she was standing outside her door

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F 323	Continued From page 18	F 323		

yelling help me help me. She stated she had fallen out of bed, crawled to the chair and gotten herself up Neuro's started no pain or injuries. The post falls assessment dated 11/16/16, by the RN indicated the current interventions identified were lights on and call light in place. The assessment noted factors contributing to falls was confusion and the measures taken to prevent further falls was to have lights on at all times. The care plan and nursing care sheets were not updated.

A PN from 11/22/16, by a LPN noted R25 was sitting on the floor at 4:07 a.m. when staff was checking on resident. R25 was incontinent of urine, denied pain, had shoes and brief off. R25 stated she was coming from the bathroom, had a history of bladder dribbling per and post bathroom voiding, vital signs and neuro checks monitored. R25 was assisted
to the bathroom and ambulated well. R25 denied bumping head. There were no areas of concern. Interventions were in place from prior falls additional intervention added "use call light added to her wall." A comprehensive falls assessment was not completed to evaluate risk factors or evaluate current interventions.

The PN dated 11/26/16, at 8:06 p.m. by LPN noted fall follow up, R25 remained in and out of room with walker, up numerous times through out the night, bed alarm in place. No injuries from past falls.

A PN dated 12/1/16, at 4:00 a.m. noted R25 sitting on the floor next to bed, sitting on her buttocks with feet out in front of her, back against the bed, resident fully conscious, movement of all 4 extremities, no injuries. Resident assisted off floor with two staff. A comprehensive falls

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	245251	A. BUILDING _____ B. WING _____	12/08/2016

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F 323	Continued From page 19	F 323		

assessment was not completed to evaluate risk factors or evaluate current interventions.

On 12/6/16, at 5:15 p.m. R25 was observed to ambulate independently using a FWW with staff walking next to her to the dining room.

On 12/7/16, at 7:17 a.m. R25 was observed to be in bed sleeping with a FWW next to her bed. R25 appeared to be sleeping until 9:15 a.m. At that time R25 was interviewed and stated she was not ready to get up and did not want breakfast. A bed alarm was observed on R25's bed.

On 12/7/16, at 7:31 a.m. nursing assistants (NA)-A and B stated R25 had a clip bed alarm during the night because she got up a lot during the night to go to the bathroom. NA-B stated R25 forgot she went to the bathroom and then wants to go again. NA-B added R25 wants to go to the bathroom a lot.

On 12/7/16, at 11:35 a.m. RN-A reviewed R25's electronic medical record and stated there were not post falls assessments completed after R25 fell on 11/22/16, and 12/1/16. RN-A stated the LPN's may not always think to complete that assessment even if they have done it in the past. RN-A was not aware R25 had a bed alarm and did not know who initiated it. RN-A reviewed R25's PN's and stated it was started on 12/1/16. At that time RN-A updated R25's care plan in the electronic record to read "Bed alarm on bed to alert staff when getting up."

On 12/7/16, at 2:43 p.m. the director of nursing (DON) stated the bed alarm was added as an intervention after R25's falls were discussed in the interdisciplinary team (IDT) meeting. The

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	245251	A. BUILDING _____ B. WING _____	12/08/2016

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F 323	Continued From page 20 DON stated falls were always discussed during IDT meetings but she did not document the discussion or the interventions. On 12/8/16, at 9:00 a.m. the DON confirmed there were no comprehensive fall assessments of R25's falls from 11/22/16, and 12/1/16, to evaluate the care plan and determine if interventions were effective. The DON verified the care plan was not updated and there were no new interventions added since R25's initial care plan. The DON added there were times when she was the only nurse and did not always have the time to complete the paper work. The Falls policy reviewed on 11/16, indicated residents who experience a fall will have a comprehensive assessment following the fall within 24 hours. The resident's care plan will be updated if indicated. The nurse working at the time of the fall will gather information listed below and chart accordingly and activate further interventions as deemed necessary. If an LPN, then data is gathered, and the oncoming RN is notified of the need for a comprehensive assessment.	F 323		
F 329 SS=E	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or	F 329		12/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	12/08/2016

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F 329	Continued From page 21 (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure tapering of antidepressant medications was attempted or contraindications to tapering were documented for 2 of 5 residents (R21, R7) and failed to ensure a rationale for duplicative antidepressant therapy was documented for 1 of 5 residents (R11) reviewed for unnecessary medications. Findings include: R21 received antidepressant medication (Celexa) and the record lacked documentation of an attempt to or contraindication of tapering the medication. R21's Resident Face Sheet dated 12/7/16, indicated R21 had diagnoses which included delusional disorders, depressive episodes, and Alzheimer's disease. R21's annual Minimum Data Set (MDS) dated 10/16/16, indicated R21 had severe cognitive impairment and required limited assistance of one staff for dressing and personal hygiene. The MDS indicated staff assessment of R21's mood	F 329	On 12/27/16 mental health physician for R21 and R7 were contacted regarding need gradual dose reductions(GDR). Appointments scheduled to address with both residents after the holidays and earliest appointments available. R11 Primary physician was contacted on 12/8/16 with orders to see mental health provider for use off psychotropic medications and need for duplicative therapy documentation. Appointment was set up for first possible opening with mental health physician in January of 2017. Chart review was completed by Pharmacist on 12/30/16 and Recommendations given to nursing team. DON audited charts on 12/31/16 and found that no gradual dose reductions were missed for any other residents at this time, nor was duplicative therapy rationales missed. Resident medication reductions will be monitored by DON for proper compliance	

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F 329	Continued From page 22 included the following symptoms: little interest or pleasure in doing things and trouble falling or staying asleep or sleeping too much 2-6 days and feeling tired or having little energy 7-11 days of the assessment period. The MDS also indicated R21 exhibited no psychosis, behavioral symptoms, or wandering, but exhibited rejection of care on 1-3 days of the assessment period. The MDS futher indicated R21 received antipsychotic and antidepressant medications daily. R21's Behavioral Symptoms Care Area Assessment (CAA) dated 10/16/16, indicated R21 had Alzheimer's disease and wandered throughout the day and at night. Mood and other behaviors included sundowning in the afternoons. The physician had chosen to help that with the antidepressant Celexa (citalopram) which had helped greatly. R21 had been on Seroquel (quetiapine) since admission, for hallucinations. R21's whereabouts needed to be monitored to assure safety and prevent altercations with others. The CAA also indicated R21 was "bossy". R21's Psychotropic Medication Use CAA dated 10/16/16, indicated the care area was triggered due to the use of Seroquel (quetiapine). R21's son stated R21 was significantly more paranoid and irritable. R21 experienced delirium due to hospitalization. Seroquel was started on 10/30/15, and had been helpful. The Seroquel dose had been decreased from 25 milligrams (mg) twice daily to 12.5 mg at bedtime. R21's Physician Order Report dated 11/7/16 - 12/7/16, indicated R21 had medication orders which included Celexa (citalopram) 20 mg once a morning for depressive episodes.	F 329	with current psychotropic medication policy. If recommendations are not addressed by provider during MD rounds a fax will be sent for follow up. If no response to fax in 1 weeks time a personal visit with MD will be set up by DON. Updated monitoring sheet implemented by DON on 12/29/16 so as to better track GDR and results. Random audits will be performed by DON or designee to assure proper compliance with gradual dose reductions and duplicative therapy documentation. Audits will be completed monthly for 2 quarters of consecutive compliance. Additional audits will be performed if deemed necessary by IDT. Audit finding will be discussed at weekly Interdisciplinary team (IDT) meetings as well as quarterly Quality Assurance meetings.	

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 329	Continued From page 23	F 329		

R21's undated Care Plan identified R21 received antipsychotic medication related to Alzheimer's dementia, delirium exhibited while in the hospital, sundowning and received the antidepressant Celexa (started 1/30/16) with a goal R21 would be prescribed the lowest effective dose of medication. The Care Plan directed staff to administer medications Seroquel and Celexa, monitor resident's behavior and response to medication, document resident behavior and approaches tried, implement a behavior management plan as needed, attempt non-pharmacological approaches such as 1:1, redirect, folding clothes, walk, movie, game, coffee, food or snack and pharmacy consultant review.

On 12/7/2016, at 12:57 p.m. R21 was observed to ambulate with assist of nursing assistant (NA)-A from the dining room to the common area. NA-A maintained a patient and calm approach and provided cues for R21 to sit in a chair in the lounge area. Interaction between NA-A and R21 were pleasant. No negative resident behavior observed.

Review of Pharmacist's Problem List form identified a pharmacist reviewed R21's medication regimen monthly. On 1/31/16, the pharmacist recommended documentation regarding behaviors and the need to initiate Celexa for R21. The pharmacist also recommended documentation regarding effectiveness and side effects of the medication. On 2/24/16, the pharmacist recommended appropriate behaviors be identified, and address if behaviors were compromising the ability to care for R21 and why non-pharmacological

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

(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 329	Continued From page 24	F 329		

interventions were not enough. No recommendations regarding tapering of Celexa were made in any subsequent reviews of R21's medication regimen.

Review of R21's physician notes from 2/11/16, to present revealed the following:
--On 2/11/16, the physician indicated R21 seems to be doing better now with sundowning since starting Celexa. We will continue her on that medication. I think we should continue her on the Seroquel at night as well since she is doing quite well and I do want to give the Celexa a few months to work. Eventually we could consider trying to decrease.
--On 3/11/16, the physician indicated: R21 is doing better with behaviors with Celexa and Seroquel and I do think we should continue these currently.
--On 5/6/16, the physician indicated: We are decreasing her Seroquel today. We will see how she does with that and maybe she can be totally off it within a few months. We will keep her on the Celexa though as it seems to be doing well with her mood and behaviors are doing fairly well at this point.

No further recommendations regarding tapering Celexa or rationale for continued use were made by the physician.

On 12/08/2016, at 8:54 a.m. the director of nursing (DON) confirmed tapering of R21's antidepressant had not been attempted nor had contraindications to tapering been documented.

R7 received the antidepressant medication (Lexapro) and the record lacked documentation of an attempt or contraindication of tapering the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 25	F 329		

medication.

R7's annual MDS dated 9/18/16, indicated R7 had diagnoses which included Alzheimer's disease, dementia, depression, psychotic disorder, mood disorder, dissociative and conversion disorders, and borderline personality disorder. The MDS indicated R7 had severe cognitive impairment and required extensive assistance of 1-2 staff for all activities of daily living. The MDS indicated staff assessment of R7's mood included the following symptoms: little interest or pleasure in doing things, trouble falling or staying asleep, feeling tired or having little energy for 2-6 days of the assessment period. The MDS also indicated R7 exhibited no psychosis, verbal behaviors directed toward others, other behavioral symptoms not directed at others, rejection of care or wandering, but had physical behavior symptoms directed toward other 1-3 days during the assessment period. The MDS further indicated R7 received antipsychotic and antidepressant and medications daily.

R7's Behavioral Symptoms CAA dated 9/18/16, indicated R7 triggered for behavioral problems, diagnosis of dementia with behavioral disturbance, explosive behavior, agitation and hard of hearing. The CAA indicated R7's behaviors were charted on every shift and R7 had refusal of cares, resistive with cares, had no attempts to elope, or pull or knock on exit doors. The CAA also indicated R7 saw a mental health provider for behavior and medication management and received Seroquel 12.5 mg in the morning, 25 mg in the afternoon and 100 mg at bedtime and Lexapro 10 mg in the morning.

R7's Psychotropic Medication Use CAA dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 26	F 329		

9/18/16, indicated R7 was on Seroquel and Lexapro and had a diagnosis of dementia with behavioral disturbances. The CAA also indicated the medications seemed effective without side effects. The CAA futher indicated the facility had been trying to reduce the dose of R7's Seroquel and R7's behaviors were monitored and charted on every shift as needed. The CAA indicated there had been no change in this area.

R7's Physician Order Report dated 11/8/16 - 12/8/16, indicated R7 had medication orders that included Lexapro 10 mg once a day for major depressive disorder with a start date of 9/8/09.

R7's undated Care Plan indicated R7 received antipsychotic and antidepressant medication due to diagnoses of depression, Alzheimer's disease and dementia with behavioral disturbance with a goal R7 would be prescribed the lowest effective dose of the medication. The Care Plan directed staff to administer Seroquel and Lexapro as ordered, assess and record the effectiveness of drug treatment, monitor and report signs of sedation, hypotension or anticholinergic symptoms and monitor resident behavior and response to medication. The Care Plan also identified R7 had target behaviors of: history of being easily annoyed, negative statements, swearing, history of physical aggression, picks nose causing nosebleeds and putting inedible object in mouth. The Care Plan directed staff to monitor R7's mouth, provide appointments with psychiatry as needed, if R7 becomes physical, protect other residents and get another staff member to assist. The Care Plan also directed staff to implement non-pharmacological interventions such as providing a doll to hold when sitting in chair and maintaining a calm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

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F 329	Continued From page 27 environment and approach to resident On 12/6/16, at 4:35 p.m. R7 was observed participating in a bean bag toss activity. Activity aide (AA)-B assisted and encouraged R7 to participate in the game. AA-B and R7 interactions were calm and pleasant. R7 was engaged in the activity, no behaviors observed. On 12/7/16, at 7:16 a.m. R7 was observed up and dressed and ambulating in the hall with NA-A and the use of a walker and gait belt. R7 ambulated to the common area and was seated in a recliner. No behaviors observed. Review of Pharmacist's Problem List form identified a pharmacist reviewed R7's medication regimen monthly. On 4/26/16, the pharmacist recommended to continue to document on behaviors since decrease in Seroquel. On 8/30/16, the pharmacist recommended to continue to document specific target behaviors. No recommendations regarding tapering of Lexapro were made in reviews of R7's medication regimen. R7's record lacked physician documentation of contraindications for tapering Lexapro. On 12/8/16, at 9:32 a.m. DON confirmed tapering of R7's antidepressant had not been attempted nor had contraindications to tapering been documented. R11 received the antidepressant medications Zoloft (sertraline) and Remeron (mirtazipine) and the record lacked rationale for the use of duplicate therapy.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

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F 329	Continued From page 28	F 329		

R11's quarterly MDS dated 11/13/16, indicated R11 had diagnoses which included Alzheimer's disease, dementia, anxiety disorder, depression, psychotic disorder and conduct disorder. The MDS indicated R11 had moderate cognitive impairment, required extensive assist of 1 staff for personal hygiene and limited assist of 1 staff for dressing. The MDS indicated staff assessment of R11's mood included the following symptoms: feeling tired or having little energy and poor appetite or overeating. The mood assessment also indicated R11 was short tempered, easily annoyed 2-6 days during the assessment period. The MDS also indicated R11 exhibited no psychosis, wandering, verbal behaviors or other behavior symptoms not directed at others, but had physical behavior symptoms directed toward others and rejection of care 1-3 days during the assessment period. The MDS further indicated R11 received antipsychotic, antidepressant and antianxiety medications daily.

R11's Behavioral Symptoms CAA dated 8/22/16, indicated R11 exhibited numerous long standing behavioral issues which included poor impulse control, confusion, talking and yelling, wandering, swearing, delusions, exit seeking and demands to leave the facility. The CAA indicated at times R11 refused to eat or come out of his room. The CAA also indicated R11 liked the "Twins" games, so staff would see if they could get some of the games on. The CAA futher indicated R11 was on psychotropic medication for mood and behaviors and did take them willingly.

R11's Psychotropic Medication Use CAA dated 8/22/16, indicated R11 was on psychotropic medications and had a stay at a psychiatric

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 29	F 329		

hospital prior to admission to the facility. The CAA indicated R11 had diagnoses of depression, anxiety, and Alzheimer's disease with behavior and conduct issues. The CAA indicated R11 was on lorazepam, Risperdal, Remeron, Zoloft, and Seroquel as needed and the facility would monitor side effects and effectiveness of the medications.

R11's Physician Order Report dated 11/7/16 - 12/7/16, indicated R11 had medication orders that included Remeron (mirtazapine) 15 mg at bedtime for major depressive disorder and sertraline 100 mg once a morning for major depressive disorder.

R11's undated Care plan indicated R11 received antipsychotic medication: risperidone, antidepressant medications: Remeron and Zoloft and antianxiety medication: lorazepam with a goal R11 would be prescribed the lowest effective dose of medication. The Care Plan directed staff to assess if R11's behavioral symptoms presented a danger to the resident and/or others, intervene as needed, implement a behavior management plan with therapeutic approaches and interventions, attempt non-pharmacological interventions, and monitor R11's behavior, mood and response to medication for effectiveness and adverse reactions.

On 12/6/16, at 3:33 p.m. R11 was observed wheeling himself independently via wheelchair in the common area. R11 was well groomed and wearing glasses. R11 transferred independently to a chair in the lounge area and began watching television. No behaviors observed.
--At 4:12 p.m. licensed practical nurse (LPN)-A brought R11 his medications. LPN-A's approach was calm and pleasant. R11's response was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

(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 329	Continued From page 30	F 329		

short and abrupt. LPN-A stated R11 did not like loud noises other than the television, for example did not like loud activities such as piano music.
--At 4:13 p.m. AA-A approached R11 and invited him to attend a game activity. R11 refused.
--At 4:55 p.m. LPN-A stated the resident had hallucinations at times and stated today he had told her someone "crapped in his bed".

Review of Pharmacist's Problem List form identified a pharmacist had reviewed R11's medication regimen monthly since admission. On 11/23/16, the pharmacist indicated R11 received Remeron and sertraline for depression and Risperdal for psychosis. The pharmacist recommended documentation of how the medications were helping with target behaviors. The pharmacist did not request a rationale for the use of duplicate antidepressant therapy.

The record lacked physician documentation of a rationale for duplicate antidepressant therapy.

On 12/8/16, at 9:36 a.m. DON confirmed there was no clinical rationale for the use of duplicate antidepressant therapy documented in R11's record.

The Psychotropic Medication policy reviewed on 11/2016, indicated the facility would make every effort to comply with state and federal regulations related to the use of psychopharmacological medications to include regular review for continued need, appropriate dosage, side effects, risk and/or benefits. The policy also indicated adequate indications for the use of all psychotropic medication will be listed in residents' plan of care along with MAR [medication administration record]. The policy further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

(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 329	Continued From page 31 indicated gradual dose reduction would be done every 6 months for those residents who received psychotropic medication. If GDR was contraindicated for resident, physician to document clinical reasoning in progress notes every six months.	F 329		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical	F 428		12/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

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F 428	Continued From page 32 director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the consultant pharmacist identified the need for reduction in antidepressant medications or ensure contraindications for reduction were documented for 2 of 5 residents (R21, R7) and failed to ensure a rationale for duplicate antidepressant therapy was documented for 1 of 5 residents (R11) reviewed for unnecessary medications. Findings include: R21 received an antidepressant medication (Celexa) and the pharmacist failed to identify the lack of documentation for a reduction or contraindication of reduction for the medication. R21's Resident Face Sheet dated 12/7/16,	F 428	On 12/27/16 mental health physician for R21 and R7 were contacted regarding need for GDR. Appointments scheduled to address with both residents after the holidays and earliest appointments available. R11 primary physician was contacted on 12/8/16 with orders to see mental health provider for use of psychotropic medications and need for duplicative therapy documentation. Appointment was set up for first possible opening with mental health physician in January of 2017 Chart review was completed by Pharmacist on 12/30/16 and Recommendations given to nursing team. DON audited charts on 12/31/16 and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 33 indicated R21 had diagnoses which included delusional disorders, depressive episodes, and Alzheimer's disease. R21's annual Minimum Data Set (MDS) dated 10/16/16, indicated R21 had severe cognitive impairment. The MDS indicated staff assessment of R21's mood included the following symptoms: little interest or pleasure in doing things and trouble falling or staying asleep or sleeping too much 2-6 days and feeling tired or having little energy 7-11 days of the assessment period. The MDS also indicated R21 exhibited no psychosis, behavioral symptoms, or wandering, but exhibited rejection of care on 1-3 days of the assessment period. The MDS futher indicated R21 received antipsychotic and antidepressant medications daily. R21's Behavioral Symptoms Care Area Assessment (CAA) dated 10/16/16, indicated R21 had Alzheimer's disease and wandered throughout the day and night. Mood and other behaviors included sundowning in the afternoons. The physician opted for the use of the antidepressant Celexa (citalopram) which had helped greatly. R21 had been on Seroquel (quetiapine) since admission, for hallucinations. R21's whereabouts needed to be monitored to assure safety and prevent altercations with others. The CAA also indicated R21 was "bossy". R21's Psychotropic Medication Use CAA dated 10/16/16, indicated the care area was triggered due to the use of Seroquel (quetiapine). R21's son stated R21 was significantly more paranoid and irritable. R21 experienced delirium due to hospitalization. Seroquel was started on 10/30/15, and had been helpful. The Seroquel dose had	F 428	found that no gradual dose reductions were missed for any other residents at this time, nor were duplicative therapy rationales missed. The consultant pharmacist shall review both the electronic chart and written chart for physician progress notes and MAR changes. If the pharmacist finds that during the first year an anti-psychotic medication is started that two attempts at Gradual Dose Reduction (GDR) have not been done, the pharmacist shall write in the pharmacy tab to the physician that a GDR needs to be attempted or the reason why not must be documented in a physician progress note. If such GDR is not attempted and the physician has not written a response either in the pharmacy tab or physician progress note, then the consultant pharmacist shall notify nursing who must fax to the physician the pharmacist□s request for a GDR. The response, whether facsimile or verbal, shall be further documented in the resident□s chart. For the resident to whom the GDR was not attempted, nursing must contact the physician and inform them of the F429 tag and ask if a GDR should be attempted. Whether yes or no, the physician must address this issue in a progress note to be placed in the resident□s chart. Random audits will be performed by Pharmacy Director to assure proper compliance with gradual dose reductions.Audit finding will be discussed at quarterly QA meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

(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 428	Continued From page 34	F 428		

been decreased from 25 milligrams (mg) twice daily to 12.5 mg at bedtime.

R21's Physician Order Report dated 11/7/16 - 12/7/16, indicated R21 had medication orders which included Celexa (citalopram) 20 mg once a morning for depressive episodes.

On 12/7/16, at 12:57 p.m. R21 was observed to ambulate with assist of nursing assistant (NA)-A from the dining room to the common area. No negative resident behavior observed.

Review of Pharmacist's Problem List form identified a pharmacist reviewed R21's medication regimen monthly. On 1/31/16, the pharmacist recommended documentation regarding behaviors and the need to initiate Celexa for R21. The pharmacist also recommended documentation regarding effectiveness and side effects of the medication. On 2/24/16, the pharmacist recommended appropriate behaviors be identified, if behaviors were compromising the ability to care for R21 be addressed and why non-pharmacological interventions were not enough be addressed. No recommendations regarding tapering of Celexa were made in any subsequent reviews of R21's medication regimen.

Review of R21's physician notes from 2/11/16 to present revealed there were no recommendations regarding tapering Celexa or rationale for continued use from the physician.

On 12/8/16, at 8:54 a.m. the director of nursing (DON) confirmed tapering of R21's antidepressant had not been attempted nor had contraindications to tapering been documented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 428	Continued From page 35 On 12/8/16, at 9:36 a.m. the administrator stated he would have expected the pharmacist would have identified irregularities related to the need for tapering of antidepressant medication for R21. On 12/8/16, at 10:18 a.m. the consultant pharmacist stated she would have expected the need for tapering or documentation of a contraindication to tapering to R21's antidepressant medication be identified and confirmed it had not been identified. R7 received antidepressant medication (Lexapro) and the pharmacist failed to identify the record lacked documentation of an attempt or contraindication of tapering the medication. R7's annual MDS dated 9/18/16, indicated R7 had diagnoses which included Alzheimer's disease, dementia, depression, psychotic disorder, mood disorder, dissociative and conversion disorders, and borderline personality disorder. The MDS indicated R7 had severe cognitive impairment. The MDS indicated staff assessment of R7's mood included the following symptoms: little interest or pleasure in doing things, trouble falling or staying asleep, feeling tired or having little energy for 2-6 days of the assessment period. The MDS also indicated R7 exhibited no psychosis, verbal behaviors directed toward others, other behavioral symptoms not directed at others, rejection of care or wandering, but had physical behavior symptoms directed toward other 1-3 days during the assessment period. The MDS further indicated R7 received antipsychotic and antidepressant and medications daily.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 36	F 428		

R7's Behavioral Symptoms CAA dated 9/18/16, indicated R7 triggered for behavioral problems, diagnosis of dementia with behavioral disturbance, explosive behavior, agitation and hard of hearing. The CAA indicated R7's behaviors were refusal of cares, resistive with cares, had no attempts to elope, or pull or knock on exit doors. The CAA also indicated R7 saw a mental health provider for behavioral and medication management and received Seroquel 12.5 mg in the morning, 25 mg in the afternoon and 100 mg at bedtime and Lexapro 10 mg in the morning.

R7's Psychotropic Medication Use CAA dated 9/18/16, indicated R7 was on Seroquel and Lexapro and had a diagnosis of dementia with behavioral disturbances. The CAA also indicated the medications seemed effective without side effects. The CAA futher indicated the facility had been trying to reduce the dose of R7's Seroquel and R7's behaviors were monitored. The CAA indicated there had been no change.

R7's Physician Order Report dated 11/8/16 - 12/8/16, indicated R7 had medication orders that included Lexapro 10 mg once a day for major depressive disorder with a start date of 9/8/09.

On 12/6/16, at 4:35 p.m. R7 was observed participating in a bean bag toss activity. R7 was engaged in the activity, no behaviors observed.

On 12/7/16, at 7:16 a.m. R7 was observed up and dressed and ambulating in the hall with NA-A and the use of a walker and gait belt. No behaviors observed.

Review of Pharmacist's Problem List form

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

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F 428	Continued From page 37	F 428		

identified a pharmacist reviewed R7's medication regimen monthly. On 4/26/16, the pharmacist recommended to continue to document on behaviors since decrease in Seroquel. On 8/30/16, the pharmacist recommended to continue to document specific target behaviors. No recommendations regarding tapering of Lexapro were made in reviews of R7's medication regimen.

R7's record lacked physician documentation of contraindications for tapering Lexapro.

On 12/8/16, at 9:32 a.m. the DON confirmed tapering of R7's antidepressant had not been attempted nor had contraindications to tapering been documented.

On 12/8/16, at 9:36 a.m. the administrator stated he would have expected the pharmacist would have identified irregularities related to the need for tapering of antidepressant medication for R7.

On 12/8/16, at 10:18 a.m. the consultant pharmacist stated she would have expected the need for tapering or documentation of a contraindication to tapering to R7's antidepressant medication be identified and confirmed it had not been done.

R11 received antidepressant medication Zoloft (sertraline) and Remeron (mirtazipine) and the pharmacist failed to identify the record lacked rationale for the use of duplicate therapy.

R11's quarterly MDS dated 11/13/16, indicated R11 had diagnoses which included Alzheimer's disease, dementia, anxiety disorder, depression,

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	245251	A. BUILDING _____ B. WING _____	12/08/2016

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F 428	Continued From page 38	F 428		

psychotic disorder and conduct disorder. The MDS indicated R11 had moderate cognitive impairment. The MDS indicated staff assessment of R11's mood included the following symptoms: feeling tired or having little energy and poor appetite or overeating. The mood assessment also indicated R11 was short tempered, easily annoyed 2-6 days during the assessment period. The MDS also indicated R11 exhibited no psychosis, wandering, verbal behaviors or other behavior symptoms not directed at others, but had physical behavior symptoms directed toward others and rejection of care 1-3 days during the assessment period. The MDS further indicated R11 received antipsychotic, antidepressant and antianxiety medications daily.

R11's Behavioral Symptoms CAA dated 8/22/16, indicated R11 exhibited numerous long standing behavioral issues which included poor impulse control, confusion, talking and yelling, wandering, swearing, delusions, exit seeking and demands to leave the facility. The CAA indicated at times R11 refused to eat or come out of his room. The CAA futher indicated R11 was on psychotropic medication for mood and behaviors and did take them willingly.

R11's Psychotropic Medication Use CAA dated 8/22/16, indicated R11 was on psychotropic medications and had a stay at a psychiatric hospital prior to admission to the facility. The CAA indicated R11 had diagnoses of depression, anxiety, and Alzheimer's disease with behavior and conduct issues. The CAA indicated R11 was on lorazepam, Risperdal, Remeron, Zoloft, and Seroquel as needed and the facility would monitor side effects and effectiveness of the medications.

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	245251	A. BUILDING _____ B. WING _____	12/08/2016

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F 428	Continued From page 39	F 428		

R11's Physician Order Report dated 11/7/16 - 12/7/16, indicated R11 had medication orders that included Remeron (mirtazapine) 15 mg at bedtime for major depressive disorder and sertraline 100 mg once a morning for major depressive disorder.

On 12/6/16, at 3:33 p.m. R11 was observed wheeling himself independently via wheelchair in the common area. R11 was well groomed. No behaviors observed.
--At 4:12 p.m. licensed practical nurse (LPN)-A brought R11 his medications. R11's response was short and abrupt.
--At 4:13 p.m. R11 was invited to an activity and he refused.
--At 4:55 p.m. LPN-A stated the resident had hallucination at times.

Review of Pharmacist's Problem List form identified a pharmacist had reviewed R11's medication regimen monthly since admission. On 11/23/16, the pharmacist indicated R11 received Remeron and sertraline for depression and Risperdal for psychosis. The pharmacist recommended documentation of how the medications were helping with target behaviors. The pharmacist did not request a rationale for the use of duplicative antidepressant therapy.

The record lacked physician documentation of rationale for duplicative antidepressant therapy.

On 12/8/16, at 9:36 a.m. the DON confirmed there was no clinical rationale for the use of duplicate antidepressant therapy documented in R11's record.

On 12/8/16, at 9:36 a.m. the administrator stated

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	245251	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 428	Continued From page 40 he would have expected the pharmacist would have identified irregularities related to R11's duplicate antidepressant therapy. On 12/8/16, at 10:18 a.m. the consultant pharmacist confirmed she should have identified R11's duplicate antidepressant therapy and requested a rationale from the physician for its continued use and had not done so. The Pharmacy Consultant Agreement policy revised 10/2016, indicated the consultant pharmacist would review residents charts monthly to assure all medications are prescribed with an appropriate diagnosis, are prescribed at appropriate dosage, are not prescribed any unnecessary medication and physicians are documenting appropriately on medications needing review.	F 428		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);	F 441		1/2/17

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	245251	A. BUILDING _____ B. WING _____	12/08/2016

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F 441	Continued From page 41 (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

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F 441	Continued From page 42 (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure appropriate hand hygiene was provided for 1 of 1 residents (R12) observed during a dressing change. In addition, the facility failed to develop an ongoing surveillance program to analyze patterns and trends of resident infections not treated with an antibiotic. This had the potential to affect all 23 residents residing in the facility Findings include: On 12/7/16, at 11:36 a.m. the facility infection control logs were reviewed with the director of nursing (DON). The logs were a tracking form which identified the date symptoms were identified, name of the resident, room number in which the resident resided, if the identified symptoms were new or ongoing, type of infection, if a culture was completed, the name of the organisms, and the type of antibiotic or treatment prescribed by the physician. However, the logs did not contain the tracking or trending of any illnesses which were not being treated with an antibiotic. On 12/7/16, at 11:45 a.m. the DON, also the infection control practitioner, stated only infections with prescribed antibiotics were	F 441	At the time of survey, there was monitoring in place for infections that occurred. On 12/7/16 the tracking form was updated to include the tracking of symptoms. Prior to this symptoms were monitored and tracked in the residents charts and these would only be placed in the infection log if an infection was present. On 12/7/16 DON was notified of occurrence of improper hand hygiene for R12. Education was provided immediately on 12/7/16 to all staff working on importance of proper hand hygiene. Written education was provided in communication book for all staff to review. As of 1/2/16 all illnesses and symptoms are documented in the illness/infection log, along with infections. This is in alignment with the updated infection prevention policy. It is the policy of RiverView Care Center that proper hand hygiene be used every time gloves are removed, whether hands are visibly soiled or not. Education was provided at staff meeting on 12/12/16 to assure all staff are away of the current hand hygiene policy and what the expectations are regarding compliance.	

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	245251	A. BUILDING _____ B. WING _____	12/08/2016

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F 441	Continued From page 43 tracked. She stated the facilty had not established a system to track infections which were not treated with antibiotics. A policy related to monitoring and surveillance of infections was requested and none was provided. R12's dressing change was not completed with proper hand hygiene. R12's Physician order's identified the diagnoses of dementia, malignant neoplasm of cheek mucosa, neoplasm of head, face and neck, and gastrostomy (an opening into the stomach for the introduction of food and medication status. The Physicians orders identified a dressing change to the gastrostomy tube (GT) site: cleanse with wound cleaner, rub area dry, apply Desitin as needed for redness. Place 4x4 (split gauze dressing) around site. Make sure GT disc is on top of the dressing. On 12/7/16, at 9:15 a.m. licensed practical nurse (LPN)-A asked R12 to lay down on the bed for her GT dressing change to be done. LPN-A gathered supplies and placed them on the table next to the bed. LPN-A was observed to wash her hands and apply gloves. LPN-A opened the packages. R12 exposed the GT on her abdomen. LPN-A removed the 4x4 gauze dressing from the GT site with gloved hands. Brown/green purulent drainage was observed, approximately 1 inch surrounding the GT opening on the gauze. R12's abdomen GT site was also observed to have brown/green purulent drainage. LPN-A verified the dressing and site contained brown/green purulent drainage. LPN-A discarded the soiled dressing and, without washing hands and changing gloves, obtained the wound cleanser	F 441	Staff meeting held on 12/12/16. Education was given to staff regarding new policy of tracking illnesses as well as importance of hand hygiene after removing gloves. Random audits on all shifts will be performed by DON or designee to assure proper hand hygiene compliance. Observational hand hygiene audits will be completed 4x/wk for one month, then decreased to 2x/wk for one month, followed by 1x/wk for one month. Audits on documentation will also be conducted by DON or designee to assure proper compliance with illness/infection tracking policy. Illness tracking audits will be completed 4x/wk for one month, then decreased to 2x/wk for one month, followed by 1x/wk for one month. Additional audits will be performed if deemed necessary by interdisciplinary team (IDT). Audit finding will be discussed at weekly IDT meetings as well as quarterly QA meetings.	

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	245251	A. BUILDING _____ B. WING _____	12/08/2016

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F 441	Continued From page 44 solution and a dry 4x4. LPN-A cleansed the GT site area. LPN-A discarded the soiled 4x4 cleansing gauze. LPN-A obtained a second 4x4 and dried R12's abdomen surrounding the GT site. R12's abdominal GT site was observed to be clean and no reddened skin was observed. LPN-A removed her soiled gloves and, without washing hands, donned clean gloves. LPN-A applied a clean 4x4 to the GT site. LPN-A was observed to tape the GT dressing to R12's abdomen and dated the dressing. On 12/7/16, at 9:25 a.m. LPN-A verified she did not wash her hands after removing her soiled gloves during the R12's dressing change. LPN-A verified hand hygiene should have been completed during the dressing change. On 12/7/16, at 11:55 a.m. the DON verified LPN-A should have washed her hands or at least utilized hand sanitizer during R12's dressing change. The facility "Infection Control-Dressing Change" policy, reviewed 1/14, directed staff to obtain supplies, remove soiled dressing, remove gloves, complete hand hygiene, reglove, cleanse wound site area, remove soiled gloves, provide hand hygiene, don clean gloves, apply medication (if ordered), apply clean dressing, remove gloves and provide hand hygiene.	F 441		

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	245251	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**12/06/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire marshal Division . The time of this survey RiverView Nursing Home 01 Main Building was not found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to: Marian.Whitney@state.mn.us	K 000	EPOC	

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

Electronically Signed — 01/02/2017

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
	245251	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**12/06/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 and 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 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 RiverView Nursing Home is a 1-story building without a basement. The building was constructed at 2 different times. The original building was constructed in 1974 and was determined to be of a Type II(000) construction. In 2003 the south wing addition was built with additions to and remodeling of the north wing. It was determined to be of a Type V (111) construction. In 2012 the facility reduced its licensed bed count to 24. The nursing home is divided into 2 smoke compartments and is separated from the remainder of the building by two, 2 hour fire barriers. The facility has a fire alarm system with smoke detection throughout the corridor system and in the common spaces. The fire alarm system is monitored for automatic fire department notification and is installed in accordance with NFPA 72 "The National Fire Alarm Code" .	K 000		

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	245251	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**12/06/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	**323 SOUTH MINNESOTA CROOKSTON, MN 56716**

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K 000	Continued From page 2 The sleeping rooms created in 2003 have single station smoke detectors installed, with an alarm at the nurse's station and on the corridor side of the rooms. The building has an automatic sprinkler system installed in accordance with NFPA 13 Standard for Installation of Automatic Sprinkler Systems. The facility has a capacity of 24 beds and had a census of 23 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=F	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to verify the DACT signal as required by the Life Safety Code,(LSC) 2012 edition, section 9.6.1.3 and NFPA 72, The National Fire Alarm and Signaling Code, 2010 edition, table 14.3.1. This deficient condition could delay alarm notification to emergency personnel in case of a failure and affect all 23 residents and an undetermined amount of staff and visitors.	K 345	The DACT system shall be tested, at least annually, by SIMPLEX that it is operating successfully. The record of testing, and the results of successfully passing the testing process, will be maintained in the office of the Plant Services Manager at RiverView Health and made readily available to the State Fire Marshal, upon request.	12/28/16

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K 345	Continued From page 3 Findings include: On the facility tour between 10:00 am to 1:00 pm on 12-06-2016 record review and staff interview revealed the DACT signal was not being verified. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Director.	K 345		

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 23, 2016

Mr. Paul Gaebe - Interim Administrator
Riverview Hospital & Nursing Home
323 South Minnesota
Crookston, Minnesota 56716

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5251038

Dear Mr. Gaebe - Interim:

The above facility was surveyed on December 5, 2016 through December 8, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules At the time of the survey, the survey team from the Minnesota Department of Health, 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 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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 Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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. 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 Lyla Burkman at (218) 308-2104 or email: lyla.burkman@state.mn.us.

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 if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

(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 December 5-8, 2016, 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	2 000		

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2 000	Continued From page 2 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.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section.	2 302		1/2/17

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2 302	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Alzheimer's training for 4 of 5 nursing assistants (NA-D, NA-E, NA-F, NA-G) who provided direct care services. In addition, the facility failed to provide consumers with written or electronic information regarding the Alzheimer's training program. This had the potential to affect all 23 residents residing in the facility. Findings include: NA-D was hired on 2/1/16. The employee record lacked evidence of having received the required Alzheimer's training. NA-E was hired on 10/3/16. The employee record lacked evidence of having received the required Alzheimer's training. NA-F was hired on 8/1/16. The employee record lacked evidence of having received the required Alzheimer's training. NA-G was hired on 8/15/16. The employee record lacked evidence of having received the required Alzheimer's training. On 12/7/16, at 1:25 p.m. the activity director/social service designee (AD/SSD) and administrator indicated they had not provided written or electronic notice regarding Alzheimer's training to their consumers as required. The AD/SSD indicated they had a brochure available for the facility consumers, however, confirmed the	2 302	Corrected	

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2 302	Continued From page 4 brochure lacked a description of the training program and the frequency of the training. On 12/7/16, at 2:10 p.m. the director of nursing (DON) confirmed NA-D, NA-E, NA-F and NA-G had not completed the required Alzheimer's training. Although requested, no policy related to Alzheimer's training was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could develop and implement policies and procedures related to the required Alzheimer's training program requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days	2 302		
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 record review the facility failed to provide repositioning for 1 of 1 (R10) resident observed for positioning/toileting. In addition, the facility failed	2 565	Corrected	1/2/17

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2 565	Continued From page 5 to ensure behavior monitoring was completed for 2 of 2 clients (R5, R13) reviewed for unnecessary medications. R10's Care Plan revised 9/22/16, indicated R10 required extensive assistance of two staff with bed mobility, transfers and toileting. The care plan indicated R10 had functional incontinence and was always incontinent. The care plan directed staff to check and change R10's brief every two hours. The current nursing assistant (NA)group assignment sheet indicated all residents were to be toileted every 2-3 hours unless otherwise stated. On 12/7/16, at 7:20 a.m. R10 was observed to be in bed fully dressed, NA-B stated at that time she had to find someone to help her transfer R10 to the Geri-chair with the Hoyer lift. At 7:29 a.m. NA-B and NA-A were observed to transfer R10 from the bed with a Hoyer lift to the Geri-chair. R10 was wheeled to the dining room for breakfast. On 12/7/16, at 11:15 p.m. NA-A was observed to wheel R10 who was sitting in the geri-chair into R10's room. NA-A stated R10 had been in the chair since before breakfast and had not been repositioned or checked for incontinence since R10 was assisted out of bed. At that time NA-A and NA-C transferred R10 to the bed and provided incontinence care. R10 was observed to be incontinent of urine. R10's skin was intact but the buttock area had red imprints from the brief and the right thigh area had a bright red mark from the elastic on the disposable brief. NA-A stated normally R10 is assisted back to bed right after breakfast but activity staff had requested	2 565		

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2 565	Continued From page 6 R10 attend an activity program. NA-A confirmed R10 had been up in the chair without repositioning/toileting for three hours and forty-five minutes. On 12/7/16 at 12:50 p.m. NA-B verified R10 was not repositioned or checked for incontinence for over 3 hours. NA-B stated they took R10 to activities. On 12/7/16, at 2:15 p.m. the director of nursing (DON)stated R10's plan of care directed staff to provide toileting or incontinence care every two hours. The DON verified she expected staff to follow the resident care plan. The DON added staff could have provided incontinence care and then taken R10 to activities. The Care Plan policy, reviewed on 11/16, indicated each resident will have a care plan evaluated and revised as necessary to reflect the resident's current status. The policy indicated the plan of care would be developed by using individual resident assessment data and resident's expectation and customary routine. The policy indicated qualified individuals would implement identified interventions/approaches in the Care Plan. R5 received antipsychotic (Seroquel) and antianxiety (Alprazolam) medications. The clinical record lacked monitoring of individualized target behaviors. R5's Physician Order Report dated 11/7/16-12/7/16, indicated R5 had diagnoses of psychosis (lack of contact with reality), and anxiety. The report further identified the prescribed medications of alprazolam (antianxiety medication) and Seroquel (antipsychotic medication).	2 565		

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2 565	Continued From page 7 R5's Care Plan dated 12/5/16, indicated R5 received antipsychotic and antianxiety medications, exhibited behaviors of irritability, anxiety, swearing, slamming walker against the wall/floor and paranoia of others stealing her items. The care plan further directed staff to quantitatively and objectively document the resident's behaviors. R5's clinical record lacked evidence of quantitatively and objectively documenting R5's behaviors. R13 received antipsychotic (Seroquel) and antianxiety (Alprazolam) medications. The clinical record lacked monitoring of individualized target behaviors. R13's Physician Order Report dated 11/7/16-12/7/16, indicated R13 had diagnoses of psychosis (lack of contact with reality), and agitation. The report further identified physician orders for the medications of Alprazolam (antianxiety) and quetiapine (Seroquel) (antipsychotic medication). R13's Care Plan dated 11/7/16, indicated R13 received antipsychotic and antianxiety medications, exhibited behaviors of hallucination, agitation, paranoia and anxiety. The care plan further directed staff to quantitatively and objectively document the resident's behaviors. R13's clinical record lacked evidence of quantitatively and objectively documenting R5's behaviors. On 12/8/16, at 9:00 a.m. the director of nursing (DON) verified specific target behaviors for R5 and R13 were not being monitored as directed by the care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review/ revise facility policies and procedures related to care plan implementation and provide education	2 565		

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2 565	Continued From page 8 to staff to address the importance of following each resident's care plan. Observations could be reviewed/revised for compliance. The quality assessment and assurance committee could establish a system to audit care plans and monitor for consistent implementation, to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to revise the care plan to include individualized target behaviors for the use of antipsychotic medication for 1 of of 5 residents (R21) reviewed for unnecessary medications. Finding include:	2 570	Corrected	1/2/17

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2 570	Continued From page 9 R21's Physician Order Report dated 11/7/16 - 12/7/16, indicated R21 had medication orders that included quetiapine (Seroquel) (antipsychotic) 12.5 mg at bedtime for delusional disorder, and Celexa (citalopram) (antidepressant) 20 mg once a morning for depressive episodes. R21's undated Care Plan identified R21 received antipsychotic medication related to Alzheimer's dementia, delirium exhibited while in the hospital, and sundowning and received the antidepressant Celexa (started 1/30/16) with a goal R21 would be prescribed the lowest effective dose of medication. The Care Plan directed staff to administer medications Seroquel and Celexa, monitor resident's behavior and response to medication, document resident behavior and approaches tried, implement a behavior management plan as needed, attempt non-pharmacological approaches such as 1:1, redirect, folding clothes, walk, movie, game, coffee, food or snack and pharmacy consultant review. The Care Plan lacked individualized target behaviors for the use of Seroquel. On 12/8/16, at 8:54 a.m. the director of nursing (DON) confirmed R21's care plan did not include individualized target behaviors for the use of Seroquel. The Behavior Monitoring Policy dated 11/16, indicated residents who received a behavior altering drug and/or exhibited negative behaviors would have target behaviors documented every shift. The problem behaviors would also be documented in the resident's plan of care. The policy also indicated this information was updated with any change in behavior, staff approach, resident's ability to be redirected and the addition	2 570		

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2 570	Continued From page 10 or discontinuation of a psychotropic medication. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review/ revise policies and procedures related to care plan revision and provide education to staff to address the importance of revising care plans when there has been a change in services. Resident care plans could be reviewed/ revised for compliance. The quality assessment and assurance committee could establish a system to audit care plans to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete a comprehensive falls assessment which included	2 830	Corrected	1/2/17

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2 830	Continued From page 11 root cause analysis, to evaluate care plan interventions for efficacy for 1 of 3 residents (R25) reviewed for falls. Findings included: R25's Diagnosis Report dated 10/19/16, identified diagnoses which included Alzheimer's disease and abnormal weight loss. The physician order's identified an order was received on 10/19/16, to admit R25 to the facility. R25's admission Minimum Data Set (MDS) dated 10/27/16, indicated R25 had severe cognitive impairment, required supervision (oversight, encouragement or cueing) of one staff for walking in room, bed mobility and transferring. The MDS indicated R25 required supervision and set up help only when walking in the hallway, extensive assistance of one staff for dressing and limited assistance with toileting. The MDS also indicated R25 was not steady but able to stabilize herself without human assistance when moving from a sit to stand position or when turning around. R25's Fall Care Area Assessment (CAA) dated 10/28/16, indicated R25 had fallen before admission and had impaired balance. The CAA identified R25's internal risk factors for falling as incontinence, hearing impairment, cognitive impairment, and Alzheimer's disease. The CAA indicated R25 had fallen at home on the day of admission and was evaluated at the emergency department with no injuries noted. The assessment indicated R25 walked with a wheeled walker, gait appeared steady and one staff to supervise for ambulation. A falls risk assessment completed 10/24/16, indicated R25 had a score of 9 (10 or higher	2 830		

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2 830	Continued From page 12 represents a high risk for falls). A therapy admission screen by a physical therapist (PT) dated 10/20/16, identified R25's fall before admission. The screening note indicated there were no reports of unsteadiness or loss of balance in the last 24 hours. The PT noted R25 ambulated with a front wheeled walker (FWW) and used safe technique getting in and out of chairs and is independent in toileting and self-cares. The PT noted no skilled therapy services were indicated and nursing to continue to monitor R25 for safety due to fall history. R25's care plan dated 10/24/16, indicated R25 was at risk for falling due to balance at times and previous falls at home. The interventions all dated 10/24/16, included give verbal reminders not to ambulate/transfer without assistance, keep call light in reach at all times, obtain PT consult for strength training, toning, positioning, transfer training, gait training and mobility devices. The care plan also indicated staff was to provide an environment free of clutter. The care plan identified R25 as being incontinent of bowel and bladder and directed staff to toilet R25 every 2-3 hours. The Residents Progress Notes (PN) written on 11/4/16, at 11:36 p.m. by a licensed practical nurse (LPN) noted resident was yelling out for help. Staff entered room and observed R25 sitting on the floor in front of the bed. R25 stated when coming back from the bathroom she fell onto the floor attempting to get into bed. No injury noted and neurological tests (neuro checks) were initiated and within normal limits (WNL). R25 was instructed on call light use. The post falls assessment completed by a LPN on 11/4/16, indicated R25 had a history of two falls in the last	2 830		

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	00470	A. BUILDING: _____ B. WING _____	12/08/2016

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2 830	Continued From page 13 90 days with no injuries. The current interventions identified were call light and PT consult. A measure taken to prevent further falls was to assist with toileting through out the night every two hours. The care plan and nursing care sheets were not updated. A PN written by LPN on 11/10/16, noted during 4 am rounds staff observed R25 sitting on her buttocks on the floor in her room. The room was dark, the bathroom light was on and the bathroom door was shut. R25 stated she went to the bathroom and fell on the floor trying to get into bed. The resident denied pain and had full range of motion. The PN indicated R25 had a bruise on the arm from a previous fall. Neuro checks were initiated. Post fall assessment dated 11/10/16, by LPN indicated R25 had a a history of 3 falls in the last 90 days with no injuries. The current interventions identified were to check R25 through-out the night during rounds. The assessment noted the factor contributing to falls was the room was dark due to resident closing the bathroom door when leaving the bathroom. The assessment indicated the measures taken to prevent further falls were to leave the overhead light and bathroom light on at all times while resident is in room and continue with routine checks. The care plan and nursing care sheets were not updated. The PN from 11/16/16, at 6:30 p.m. by a registered nurse (RN) noted staff heard R25 hollering, she was standing outside her door yelling help me help me. She stated she had fallen out of bed, crawled to the chair and gotten herself up Neuro's started no pain or injuries. The post falls assessment dated 11/16/16, by the RN indicated the current interventions identified were lights on and call light in place. The assessment	2 830		

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2 830	Continued From page 14 noted factors contributing to falls was confusion and the measures taken to prevent further falls was to have lights on at all times. The care plan and nursing care sheets were not updated. A PN from 11/22/16, by a LPN noted R25 was sitting on the floor at 4:07 a.m. when staff was checking on resident. R25 was incontinent of urine, denied pain, had shoes and brief off. R25 stated she was coming from the bathroom, had a history of bladder dribbling per and post bathroom voiding, vital signs and neuro checks monitored. R25 was assisted to the bathroom and ambulated well. R25 denied bumping head. There were no areas of concern. Interventions were in place from prior falls additional intervention added "use call light added to her wall." A comprehensive falls assessment was not completed to evaluate risk factors or evaluate current interventions. The PN dated 11/26/16, at 8:06 p.m. by LPN noted fall follow up, R25 remained in and out of room with walker, up numerous times through out the night, bed alarm in place. No injuries from past falls. A PN dated 12/1/16, at 4:00 a.m. noted R25 sitting on the floor next to bed, sitting on her buttocks with feet out in front of her, back against the bed, resident fully conscious, movement of all 4 extremities, no injuries. Resident assisted off floor with two staff. A comprehensive falls assessment was not completed to evaluate risk factors or evaluate current interventions. On 12/6/16, at 5:15 p.m. R25 was observed to ambulate independently using a FWW with staff walking next to her to the dining room.	2 830		

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2 830	Continued From page 15 On 12/7/16, at 7:17 a.m. R25 was observed to be in bed sleeping with a FWW next to her bed. R25 appeared to be sleeping until 9:15 a.m. At that time R25 was interviewed and stated she was not ready to get up and did not want breakfast. A bed alarm was observed on R25's bed. On 12/7/16, at 7:31 a.m. nursing assistants (NA)-A and B stated R25 had a clip bed alarm during the night because she got up a lot during the night to go to the bathroom. NA-B stated R25 forgot she went to the bathroom and then wants to go again. NA-B added R25 wants to go to the bathroom a lot. On 12/7/16, at 11:35 a.m. RN-A reviewed R25's electronic medical record and stated there were not post falls assessments completed after R25 fell on 11/22/16, and 12/1/16. RN-A stated the LPN's may not always think to complete that assessment even if they have done it in the past. RN-A was not aware R25 had a bed alarm and did not know who initiated it. RN-A reviewed R25's PN's and stated it was started on 12/1/16. At that time RN-A updated R25's care plan in the electronic record to read "Bed alarm on bed to alert staff when getting up." On 12/7/16, at 2:43 p.m. the director of nursing (DON) stated the bed alarm was added as an intervention after R25's falls were discussed in the interdisciplinary team (IDT) meeting. The DON stated falls were always discussed during IDT meetings but she did not document the discussion or the interventions. On 12/8/16, at 9:00 a.m. the DON confirmed there were no comprehensive fall assessments of R25's falls from 11/22/16, and 12/1/16, to evaluate the care plan and determine if	2 830		

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2 830	Continued From page 16 interventions were effective. The DON verified the care plan was not updated and there were no new interventions added since R25's initial care plan. The DON added there were times when she was the only nurse and did not always have the time to complete the paper work. The Falls policy reviewed on 11/16, indicated residents who experience a fall will have a comprehensive assessment following the fall within 24 hours. The resident's care plan will be updated if indicated. The nurse working at the time of the fall will gather information listed below and chart accordingly and activate further interventions as deemed necessary. If an LPN, then data is gathered, and the oncoming RN is notified of the need for a comprehensive assessment. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and/or revise policies and procedures related to assessment and implementation of interventions following a fall. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	2 830		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include:	2 840		1/2/17

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2 840	Continued From page 17 B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors.	2 840		

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2 840	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely repositioning was provided for 1 of 2 residents (R10) who were at risk for developing a pressure ulcer and required every two hour repositioning assistance. Findings include: R10 was not provided repositioning on 12/7/16 from 7:30 a.m. until 11:15 a.m. (three hours and forty-five minutes). R10's change of status Minimum Data Set (MDS) dated 10/30/16, indicated R10 had severe cognitive impairment and diagnoses which included Alzheimer's disease, dementia, and anxiety. The MDS also indicated R10 required extensive assist of two people for bed mobility, transfer, dressing, toilet use and personal hygiene. The MDS further indicated R10 was at risk for the development of pressure ulcers. R10's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 10/30/16, indicated R10 was always incontinent and totally dependent on staff for assistance. The CAA indicated R10 had functional incontinence due to physical and mental impairments and wore a brief that was changed by total assist of two staff with a Hoyer lift. R10's Care Plan revised 9/22/16, indicated R10 required extensive assistance of two staff with bed mobility, transfers and toileting. The plan of care directed staff to check and change R10 ' s brief every two hours.	2 840	Corrected	

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2 840	Continued From page 19 The current nursing assistant (NA) group assignment sheet indicated all residents were to be toileted every 2-3 hours unless otherwise stated. On 12/7/16, at 7:20 a.m. R10 was observed to be in bed fully dressed. NA-B stated morning cares had just been completed and she had to find someone to help transfer R10 to the Geri-chair with the Hoyer lift. At 7:29 a.m. NA-B and NA-A were observed to transfer R10 from the bed with a Hoyer lift to the Geri-chair. R10 was wheeled to the dining room for breakfast. On 12/7/16 at 11:15 p.m. NA-A was observed to wheel R10 in the Geri-chair into R10's room. NA-A stated R10 had been up in the chair since before breakfast. R10 had not been repositioned or checked for incontinence since R10 was assisted out of bed before breakfast. At that time NA-A and NA-C transferred R10 with the Hoyer lift to the bed and provided incontinence care. R10 was observed to be incontinent of urine. R10's skin was intact. The buttock area had red imprints from the brief and the right thigh area had a bright red mark from the elastic on the disposable brief. NA-A stated normally R10 was assisted back to bed right after breakfast but activity staff had requested R10 attend an activity program. NA-A confirmed R10 had been up in the chair without repositioning for three hours and forty-five minutes. On 12/7/16 at 12:50 p.m. NA-B verified R10 was not repositioned for over 3 hours and stated R10 was taken by activity staff to attend a morning program. On 12/7/16, at 2:15 p.m. the director of nursing	2 840		

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2 840	Continued From page 20 (DON) stated R10's plan of care was to be repositioned and toileted every two hours. The DON verified she expected staff to follow the resident care plan. The DON added if resident's do go back to bed right after breakfast then they miss out on activities. The Repositioning, toileting, exercise policy reviewed 11/16, indicated resident's dependent on staff and/or requiring staff assistance will be repositioned, toileted every 2-3 hours unless otherwise indicated by their comprehensive assessment. Each resident will have a comprehensive assessment, analysis of assessment and a plan of care to determine appropriate time frames for their need to be moved, provided with exercise and toileting assistance. The policy indicated specific information necessary to provide individualized care will be provided in the care plan and on the NA care sheets with changes communicated in each shift report. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review policies and procedures, revise as needed, train staff, assess the system, monitor, evaluate to assure residents who are incontinent of urine, receive the necessary services and care following each episode of incontinence. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 840		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position	2 905		1/2/17

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2 905	Continued From page 21 of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely repositioning was provided for 1 of 2 residents (R10) who were at risk for developing a pressure ulcer and required every two hour repositioning assistance. Findings include: R10 was not provided repositioning on 12/7/16 from 7:30 a.m. until 11:15 a.m. (three hours and forty-five minutes). R10's change of status Minimum Data Set (MDS) dated 10/30/16, indicated R10 had severe cognitive impairment and diagnoses which included Alzheimer's disease, dementia, and anxiety. The MDS also indicated R10 required extensive assist of two people for bed mobility, transfer, dressing, toilet use and personal hygiene. The MDS further indicated R10 was at risk for the development of pressure ulcers. R10's Pressure Ulcer Care Area Assessment (CAA) dated 10/30/16, indicated R10 was at risk for pressure ulcers due to incontinence, cognitive loss and immobility. The CAA also indicated R10 was totally dependent on staff for bed mobility and required a Hoyer (mechanical) Lift for all	2 905	Corrected	

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2 905	Continued From page 22 mobility and also required a regular schedule of turning. R10's Braden Scale for predicting pressure sore risk dated 10/24/16, indicated R10 was at high risk for developing pressure sores. R10's Tissue Tolerance Assessment (observation to determine positioning schedule) dated 10/28/16, indicated R10 was on an every two hour repositioning schedule and showed no signs of redness over bony prominences at the two hour assessment. R10's Care Plan revised 9/22/16, indicated R10 required extensive assistance of two staff with bed mobility, transfers and toileting. The plan directed staff to use Hoyer lift at all times. The plan of care also directed staff to check and change R10's brief every two hours. The plan of care did not identify R10's repositioning needs. The current nursing assistant (NA) group assignment sheet did not indicate how often R10's was to be repositioned, however, the assignment sheet indicated all residents were to be toileted every 2-3 hours unless otherwise stated. On 12/7/16, at 7:20 a.m. R10 was observed to be in bed fully dressed. NA-B stated morning cares had just been completed and she had to find someone to help transfer R10 to the Geri-chair with the Hoyer lift. At 7:29 a.m. NA-B and NA-A were observed to transfer R10 from the bed with a Hoyer lift to the Geri-chair. R10 was wheeled to the dining room for breakfast. On 12/7/16 at 11:15 p.m. NA-A was observed to wheel R10 in the Geri-chair into R10's room. NA-A stated R10 had been up in the chair since before breakfast. R10 had not been repositioned	2 905		

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2 905	Continued From page 23	2 905		

or checked for incontinence since R10 was assisted out of bed before breakfast. At that time NA-A and NA-C transferred R10 with the Hoyer lift to the bed and provided incontinence care. R10 was observed to be incontinent of urine. R10's skin was intact. The buttock area had red imprints from the brief and the right thigh area had a bright red mark from the elastic on the disposable brief. NA-A stated normally R10 was assisted back to bed right after breakfast but activity staff had requested R10 attend an activity program. NA-A confirmed R10 had been up in the chair without repositioning for three hours and forty-five minutes.

On 12/7/16 at 12:50 p.m. NA-B verified R10 was not repositioned for over 3 hours and stated R10 was taken by activity staff to attend a morning program.

On 12/7/16, at 2:15 p.m. the director of nursing (DON) stated R10's plan of care was to be repositioned and toileted every two hours. The DON verified she expected staff to follow the resident care plan. The DON added if resident's do go back to bed right after breakfast then they miss out on activities.

The Repositioning, toileting, exercise policy reviewed 11/16, indicated resident's dependent on staff and/or requiring staff assistance will be repositioned, toileted every 2-3 hours unless otherwise indicated by their comprehensive assessment. Each resident will have a comprehensive assessment, analysis of assessment and a plan of care to determine appropriate time frames for their need to be moved, provided with exercise and toileting assistance. The policy indicated specific information necessary to provide individualized

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2 905	Continued From page 24 care will be provided in the care plan and on the NA care sheets with changes communicated in each shift report. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure residents receive the repositioning assistance according the assessed need. The DON or designee could develop an auditing system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815;	21390		1/2/17

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RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

(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
21390	Continued From page 25 G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure appropriate hand hygiene was provided for 1 of 1 residents (R12) observed during a dressing change. In addition, the facility failed to develop an ongoing surveillance program to analyze patterns and trends of resident infections not treated with an antibiotic. This had the potential to affect all 23 residents residing in the facility Findings include: On 12/7/16, at 11:36 a.m. the facility infection control logs were reviewed with the director of nursing (DON). The logs were a tracking form which identified the date symptoms were identified, name of the resident, room number in which the resident resided, if the identified symptoms were new or ongoing, type of infection, if a culture was completed, the name of the organisms, and the type of antibiotic or treatment prescribed by the physician. However, the logs did not contain the tracking or trending of any illnesses which were not being treated with an antibiotic. On 12/7/16, at 11:45 a.m. the DON, also the infection control practitioner, stated only infections with prescribed antibiotics were	21390	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

(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
21390	Continued From page 26 tracked. She stated the facilty had not established a system to track infections which were not treated with antibiotics. A policy related to monitoring and surveillance of infections was requested and none was provided. R12's dressing change was not completed with proper hand hygiene. R12's Physician order's identified the diagnoses of dementia, malignant neoplasm of cheek mucosa, neoplasm of head, face and neck, and gastrostomy (an opening into the stomach for the introduction of food and medication status. The Physicians orders identified a dressing change to the gastrostomy tube (GT) site: cleanse with wound cleaner, rub area dry, apply Desitin as needed for redness. Place 4x4 (split gauze dressing) around site. Make sure GT disc is on top of the dressing. On 12/7/16, at 9:15 a.m. licensed practical nurse (LPN)-A asked R12 to lay down on the bed for her GT dressing change to be done. LPN-A gathered supplies and placed them on the table next to the bed. LPN-A was observed to wash her hands and apply gloves. LPN-A opened the packages. R12 exposed the GT on her abdomen. LPN-A removed the 4x4 gauze dressing from the GT site with gloved hands. Brown/green purulent drainage was observed, approximately 1 inch surrounding the GT opening on the gauze. R12's abdomen GT site was also observed to have brown/green purulent drainage. LPN-A verified the dressing and site contained brown/green purulent drainage. LPN-A discarded the soiled dressing and, without washing hands and changing gloves, obtained the wound cleanser solution and a dry 4x4. LPN-A cleansed the GT	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	12/08/2016

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RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

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21390	Continued From page 27 site area. LPN-A discarded the soiled 4x4 cleansing gauze. LPN-A obtained a second 4x4 and dried R12's abdomen surrounding the GT site. R12's abdominal GT site was observed to be clean and no reddened skin was observed. LPN-A removed her soiled gloves and, without washing hands, donned clean gloves. LPN-A applied a clean 4x4 to the GT site. LPN-A was observed to tape the GT dressing to R12's abdomen and dated the dressing. On 12/7/16, at 9:25 a.m. LPN-A verified she did not wash her hands after removing her soiled gloves during the R12's dressing change. LPN-A verified hand hygiene should have been completed during the dressing change. On 12/7/16, at 11:55 a.m. the DON verified LPN-A should have washed her hands or at least utilized hand sanitizer during R12's dressing change. The facility "Infection Control-Dressing Change" policy, reviewed 1/14, directed staff to obtain supplies, remove soiled dressing, remove gloves, complete hand hygiene, reglove, cleanse wound site area, remove soiled gloves, provide hand hygiene, don clean gloves, apply medication (if ordered), apply clean dressing, remove gloves and provide hand hygiene. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding infection control practices and a facility wide infection control program. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	12/08/2016

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 28	21530		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality	21530		1/2/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21530	Continued From page 29 assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the consultant pharmacist identified the need for reduction in antidepressant medications or ensure contraindications for reduction were documented for 2 of 5 residents (R21, R7) and failed to ensure a rationale for duplicate antidepressant therapy was documented for 1 of 5 residents (R11) reviewed for unnecessary medications. Findings include: R21 received an antidepressant medication (Celexa) and the pharmacist failed to identify the lack of documentation for a reduction or contraindication of reduction for the medication. R21's Resident Face Sheet dated 12/7/16, indicated R21 had diagnoses which included delusional disorders, depressive episodes, and Alzheimer's disease. R21's annual Minimum Data Set (MDS) dated 10/16/16, indicated R21 had severe cognitive impairment. The MDS indicated staff assessment of R21's mood included the following symptoms: little interest or pleasure in doing things and trouble falling or staying asleep or sleeping too much 2-6 days and feeling tired or having little energy 7-11 days of the assessment period. The MDS also indicated R21 exhibited no psychosis, behavioral symptoms, or wandering, but exhibited rejection of care on 1-3 days of the assessment period. The MDS futher indicated R21 received antipsychotic and antidepressant medications	21530	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21530	Continued From page 30 daily. R21's Behavioral Symptoms Care Area Assessment (CAA) dated 10/16/16, indicated R21 had Alzheimer's disease and wandered throughout the day and night. Mood and other behaviors included sundowning in the afternoons. The physician opted for the use of the antidepressant Celexa (citalopram) which had helped greatly. R21 had been on Seroquel (quetiapine) since admission, for hallucinations. R21's whereabouts needed to be monitored to assure safety and prevent altercations with others. The CAA also indicated R21 was "bossy". R21's Psychotropic Medication Use CAA dated 10/16/16, indicated the care area was triggered due to the use of Seroquel (quetiapine). R21's son stated R21 was significantly more paranoid and irritable. R21 experienced delirium due to hospitalization. Seroquel was started on 10/30/15, and had been helpful. The Seroquel dose had been decreased from 25 milligrams (mg) twice daily to 12.5 mg at bedtime. R21's Physician Order Report dated 11/7/16 - 12/7/16, indicated R21 had medication orders which included Celexa (citalopram) 20 mg once a morning for depressive episodes. On 12/7/16, at 12:57 p.m. R21 was observed to ambulate with assist of nursing assistant (NA)-A from the dining room to the common area. No negative resident behavior observed. Review of Pharmacist's Problem List form identified a pharmacist reviewed R21's medication regimen monthly. On 1/31/16, the pharmacist recommended documentation regarding behaviors and the need to initiate	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

(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
21530	Continued From page 31 Celexa for R21. The pharmacist also recommended documentation regarding effectiveness and side effects of the medication. On 2/24/16, the pharmacist recommended appropriate behaviors be identified, if behaviors were compromising the ability to care for R21 be addressed and why non-pharmacological interventions were not enough be addressed. No recommendations regarding tapering of Celexa were made in any subsequent reviews of R21's medication regimen. Review of R21's physician notes from 2/11/16 to present revealed there were no recommendations regarding tapering Celexa or rationale for continued use from the physician. On 12/8/16, at 8:54 a.m. the director of nursing (DON) confirmed tapering of R21's antidepressant had not been attempted nor had contraindications to tapering been documented. On 12/8/16, at 9:36 a.m. the administrator stated he would have expected the pharmacist would have identified irregularities related to the need for tapering of antidepressant medication for R21. On 12/8/16, at 10:18 a.m. the consultant pharmacist stated she would have expected the need for tapering or documentation of a contraindication to tapering to R21's antidepressant medication be identified and confirmed it had not been identified. R7 received antidepressant medication (Lexapro) and the pharmacist failed to identify the record lacked documentation of an attempt or contraindication of tapering the medication. R7's annual MDS dated 9/18/16, indicated R7	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 32	21530		

had diagnoses which included Alzheimer's disease, dementia, depression, psychotic disorder, mood disorder, dissociative and conversion disorders, and borderline personality disorder. The MDS indicated R7 had severe cognitive impairment. The MDS indicated staff assessment of R7's mood included the following symptoms: little interest or pleasure in doing things, trouble falling or staying asleep, feeling tired or having little energy for 2-6 days of the assessment period. The MDS also indicated R7 exhibited no psychosis, verbal behaviors directed toward others, other behavioral symptoms not directed at others, rejection of care or wandering, but had physical behavior symptoms directed toward other 1-3 days during the assessment period. The MDS further indicated R7 received antipsychotic and antidepressant and medications daily.

R7's Behavioral Symptoms CAA dated 9/18/16, indicated R7 triggered for behavioral problems, diagnosis of dementia with behavioral disturbance, explosive behavior, agitation and hard of hearing. The CAA indicated R7's behaviors were refusal of cares, resistive with cares, had no attempts to elope, or pull or knock on exit doors. The CAA also indicated R7 saw a mental health provider for behavioral and medication management and received Seroquel 12.5 mg in the morning, 25 mg in the afternoon and 100 mg at bedtime and Lexapro 10 mg in the morning.

R7's Psychotropic Medication Use CAA dated 9/18/16, indicated R7 was on Seroquel and Lexapro and had a diagnosis of dementia with behavioral disturbances. The CAA also indicated the medications seemed effective without side effects. The CAA futher indicated the facility had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

(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
21530	Continued From page 33	21530		

been trying to reduce the dose of R7's Seroquel and R7's behaviors were monitored. The CAA indicated there had been no change.

R7's Physician Order Report dated 11/8/16 - 12/8/16, indicated R7 had medication orders that included Lexapro 10 mg once a day for major depressive disorder with a start date of 9/8/09.

On 12/6/16, at 4:35 p.m. R7 was observed participating in a bean bag toss activity. R7 was engaged in the activity, no behaviors observed.

On 12/7/16, at 7:16 a.m. R7 was observed up and dressed and ambulating in the hall with NA-A and the use of a walker and gait belt. No behaviors observed.

Review of Pharmacist's Problem List form identified a pharmacist reviewed R7's medication regimen monthly. On 4/26/16, the pharmacist recommended to continue to document on behaviors since decrease in Seroquel. On 8/30/16, the pharmacist recommended to continue to document specific target behaviors. No recommendations regarding tapering of Lexapro were made in reviews of R7's medication regimen.

R7's record lacked physician documentation of contraindications for tapering Lexapro.

On 12/8/16, at 9:32 a.m. the DON confirmed tapering of R7's antidepressant had not been attempted nor had contraindications to tapering been documented.

On 12/8/16, at 9:36 a.m. the administrator stated he would have expected the pharmacist would have identified irregularities related to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

(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
21530	Continued From page 34 need for tapering of antidepressant medication for R7. On 12/8/16, at 10:18 a.m. the consultant pharmacist stated she would have expected the need for tapering or documentation of a contraindication to tapering to R7's antidepressant medication be identified and confirmed it had not been done. R11 received antidepressant medication Zoloft (sertraline) and Remeron (mirtazipine) and the pharmacist failed to identify the record lacked rationale for the use of duplicate therapy. R11's quarterly MDS dated 11/13/16, indicated R11 had diagnoses which included Alzheimer's disease, dementia, anxiety disorder, depression, psychotic disorder and conduct disorder. The MDS indicated R11 had moderate cognitive impairment. The MDS indicated staff assessment of R11's mood included the following symptoms: feeling tired or having little energy and poor appetite or overeating. The mood assessment also indicated R11 was short tempered, easily annoyed 2-6 days during the assessment period. The MDS also indicated R11 exhibited no psychosis, wandering, verbal behaviors or other behavior symptoms not directed at others, but had physical behavior symptoms directed toward others and rejection of care 1-3 days during the assessment period. The MDS further indicated R11 received antipsychotic, antidepressant and antianxiety medications daily. R11's Behavioral Symptoms CAA dated 8/22/16, indicated R11 exhibited numerous long standing behavioral issues which included poor impulse control, confusion, talking and yelling, wandering, swearing, delusions, exit seeking and demands to	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

(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
21530	Continued From page 35	21530		

leave the facility. The CAA indicated at times R11 refused to eat or come out of his room. The CAA futher indicated R11 was on psychotropic medication for mood and behaviors and did take them willingly.

R11's Psychotropic Medication Use CAA dated 8/22/16, indicated R11 was on psychotropic medications and had a stay at a psychiatric hospital prior to admission to the facility. The CAA indicated R11 had diagnoses of depression, anxiety, and Alzheimer's disease with behavior and conduct issues. The CAA indicated R11 was on lorazepam, Risperdal, Remeron, Zoloft, and Seroquel as needed and the facility would monitor side effects and effectiveness of the medications.

R11's Physician Order Report dated 11/7/16 - 12/7/16, indicated R11 had medication orders that included Remeron (mirtazapine) 15 mg at bedtime for major depressive disorder and sertraline 100 mg once a morning for major depressive disorder.

On 12/6/16, at 3:33 p.m. R11 was observed wheeling himself independently via wheelchair in the common area. R11 was well groomed. No behaviors observed.
--At 4:12 p.m. licensed practical nurse (LPN)-A brought R11 his medications. R11's response was short and abrupt.
--At 4:13 p.m. R11 was invited to an activity and he refused.
--At 4:55 p.m. LPN-A stated the resident had hallucination at times.

Review of Pharmacist's Problem List form identified a pharmacist had reviewed R11's medication regimen monthly since admission. On 11/23/16, the pharmacist indicated R11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

(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
21530	Continued From page 36 received Remeron and sertraline for depression and Risperdal for psychosis. The pharmacist recommended documentation of how the medications were helping with target behaviors. The pharmacist did not request a rationale for the use of duplicative antidepressant therapy. The record lacked physician documentation of rationale for duplicative antidepressant therapy. On 12/8/16, at 9:36 a.m. the DON confirmed there was no clinical rationale for the use of duplicate antidepressant therapy documented in R11's record. On 12/8/16, at 9:36 a.m. the administrator stated he would have expected the pharmacist would have identified irregularities related to R11's duplicate antidepressant therapy. On 12/8/16, at 10:18 a.m. the consultant pharmacist confirmed she should have identified R11's duplicate antidepressant therapy and requested a rationale from the physician for its continued use and had not done so. The Pharmacy Consultant Agreement policy revised 10/2016, indicated the consultant pharmacist would review residents charts monthly to assure all medications are prescribed with an appropriate diagnosis, are prescribed at appropriate dosage, are not prescribed any unnecessary medication and physicians are documenting appropriately on medications needing review. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and / or revise policies and procedures related to pharmacy reviews. Education could be provided	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 37 to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure tapering of	21535	Corrected	1/2/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

(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
21535	Continued From page 38	21535		

antidepressant medications was attempted or contraindications to tapering were documented for 2 of 5 residents (R21, R7) and failed to ensure a rationale for duplicative antidepressant therapy was documented for 1 of 5 residents (R11) reviewed for unnecessary medications.

Findings include:

R21 received antidepressant medication (Celexa) and the record lacked documentation of an attempt to or contraindication of tapering the medication.

R21's Resident Face Sheet dated 12/7/16, indicated R21 had diagnoses which included delusional disorders, depressive episodes, and Alzheimer's disease.

R21's annual Minimum Data Set (MDS) dated 10/16/16, indicated R21 had severe cognitive impairment and required limited assistance of one staff for dressing and personal hygiene. The MDS indicated staff assessment of R21's mood included the following symptoms: little interest or pleasure in doing things and trouble falling or staying asleep or sleeping too much 2-6 days and feeling tired or having little energy 7-11 days of the assessment period. The MDS also indicated R21 exhibited no psychosis, behavioral symptoms, or wandering, but exhibited rejection of care on 1-3 days of the assessment period. The MDS futher indicated R21 received antipsychotic and antidepressant medications daily.

R21's Behavioral Symptoms Care Area Assessment (CAA) dated 10/16/16, indicated R21 had Alzheimer's disease and wandered throughout the day and at night. Mood and other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

(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
21535	Continued From page 39	21535		

behaviors included sundowning in the afternoons. The physician had chosen to help that with the antidepressant Celexa (citalopram) which had helped greatly. R21 had been on Seroquel (quetiapine) since admission, for hallucinations. R21's whereabouts needed to be monitored to assure safety and prevent altercations with others. The CAA also indicated R21 was "bossy".

R21's Psychotropic Medication Use CAA dated 10/16/16, indicated the care area was triggered due to the use of Seroquel (quetiapine). R21's son stated R21 was significantly more paranoid and irritable. R21 experienced delirium due to hospitalization. Seroquel was started on 10/30/15, and had been helpful. The Seroquel dose had been decreased from 25 milligrams (mg) twice daily to 12.5 mg at bedtime.

R21's Physician Order Report dated 11/7/16 - 12/7/16, indicated R21 had medication orders which included Celexa (citalopram) 20 mg once a morning for depressive episodes.

R21's undated Care Plan identified R21 received antipsychotic medication related to Alzheimer's dementia, delirium exhibited while in the hospital, sundowning and received the antidepressant Celexa (started 1/30/16) with a goal R21 would be prescribed the lowest effective dose of medication. The Care Plan directed staff to administer medications Seroquel and Celexa, monitor resident's behavior and response to medication, document resident behavior and approaches tried, implement a behavior management plan as needed, attempt non-pharmacological approaches such as 1:1, redirect, folding clothes, walk, movie, game, coffee, food or snack and pharmacy consultant review.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

(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
21535	Continued From page 40 On 12/7/2016, at 12:57 p.m. R21 was observed to ambulate with assist of nursing assistant (NA)-A from the dining room to the common area. NA-A maintained a patient and calm approach and provided cues for R21 to sit in a chair in the lounge area. Interaction between NA-A and R21 were pleasant. No negative resident behavior observed. Review of Pharmacist's Problem List form identified a pharmacist reviewed R21's medication regimen monthly. On 1/31/16, the pharmacist recommended documentation regarding behaviors and the need to initiate Celexa for R21. The pharmacist also recommended documentation regarding effectiveness and side effects of the medication. On 2/24/16, the pharmacist recommended appropriate behaviors be identified, and address if behaviors were compromising the ability to care for R21 and why non-pharmacological interventions were not enough. No recommendations regarding tapering of Celexa were made in any subsequent reviews of R21's medication regimen. Review of R21's physician notes from 2/11/16, to present revealed the following: --On 2/11/16, the physician indicated R21 seems to be doing better now with sundowning since starting Celexa. We will continue her on that medication. I think we should continue her on the Seroquel at night as well since she is doing quite well and I do want to give the Celexa a few months to work. Eventually we could consider trying to decrease. --On 3/11/16, the physician indicated: R21 is doing better with behaviors with Celexa and Seroquel and I do think we should continue these	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 41 currently. --On 5/6/16, the physician indicated: We are decreasing her Seroquel today. We will see how she does with that and maybe she can be totally off it within a few months. We will keep her on the Celexa though as it seems to be doing well with her mood and behaviors are doing fairly well at this point. No further recommendations regarding tapering Celexa or rationale for continued use were made by the physician. On 12/08/2016, at 8:54 a.m. the director of nursing (DON) confirmed tapering of R21's antidepressant had not been attempted nor had contraindications to tapering been documented. R7 received the antidepressant medication (Lexapro) and the record lacked documentation of an attempt or contraindication of tapering the medication. R7's annual MDS dated 9/18/16, indicated R7 had diagnoses which included Alzheimer's disease, dementia, depression, psychotic disorder, mood disorder, dissociative and conversion disorders, and borderline personality disorder. The MDS indicated R7 had severe cognitive impairment and required extensive assistance of 1-2 staff for all activities of daily living. The MDS indicated staff assessment of R7's mood included the following symptoms: little interest or pleasure in doing things, trouble falling or staying asleep, feeling tired or having little energy for 2-6 days of the assessment period. The MDS also indicated R7 exhibited no psychosis, verbal behaviors directed toward others, other behavioral symptoms not directed at others, rejection of care or wandering, but had	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 42	21535		

physical behavior symptoms directed toward other 1-3 days during the assessment period. The MDS further indicated R7 received antipsychotic and antidepressant and medications daily.

R7's Behavioral Symptoms CAA dated 9/18/16, indicated R7 triggered for behavioral problems, diagnosis of dementia with behavioral disturbance, explosive behavior, agitation and hard of hearing. The CAA indicated R7's behaviors were charted on every shift and R7 had refusal of cares, resistive with cares, had no attempts to elope, or pull or knock on exit doors. The CAA also indicated R7 saw a mental health provider for behavior and medication management and received Seroquel 12.5 mg in the morning, 25 mg in the afternoon and 100 mg at bedtime and Lexapro 10 mg in the morning.

R7's Psychotropic Medication Use CAA dated 9/18/16, indicated R7 was on Seroquel and Lexapro and had a diagnosis of dementia with behavioral disturbances. The CAA also indicated the medications seemed effective without side effects. The CAA futher indicated the facility had been trying to reduce the dose of R7's Seroquel and R7's behaviors were monitored and charted on every shift as needed. The CAA indicated there had been no change in this area.

R7's Physician Order Report dated 11/8/16 - 12/8/16, indicated R7 had medication orders that included Lexapro 10 mg once a day for major depressive disorder with a start date of 9/8/09.

R7's undated Care Plan indicated R7 received antipsychotic and antidepressant medication due to diagnoses of depression, Alzheimer's disease and dementia with behavioral disturbance with a goal R7 would be prescribed the lowest effective

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 43	21535		

dose of the medication. The Care Plan directed staff to administer Seroquel and Lexapro as ordered, assess and record the effectiveness of drug treatment, monitor and report signs of sedation, hypotension or anticholinergic symptoms and monitor resident behavior and response to medication. The Care Plan also identified R7 had target behaviors of: history of being easily annoyed, negative statements, swearing, history of physical aggression, picks nose causing nosebleeds and putting inedible object in mouth. The Care Plan directed staff to monitor R7's mouth, provide appointments with psychiatry as needed, if R7 becomes physical, protect other residents and get another staff member to assist. The Care Plan also directed staff to implement non-pharmacological interventions such as providing a doll to hold when sitting in chair and maintaining a calm environment and approach to resident

On 12/6/16, at 4:35 p.m. R7 was observed participating in a bean bag toss activity. Activity aide (AA)-B assisted and encouraged R7 to participate in the game. AA-B and R7 interactions were calm and pleasant. R7 was engaged in the activity, no behaviors observed.

On 12/7/16, at 7:16 a.m. R7 was observed up and dressed and ambulating in the hall with NA-A and the use of a walker and gait belt. R7 ambulated to the common area and was seated in a recliner. No behaviors observed.

Review of Pharmacist's Problem List form identified a pharmacist reviewed R7's medication regimen monthly. On 4/26/16, the pharmacist recommended to continue to document on behaviors since decrease in Seroquel. On 8/30/16, the pharmacist recommended to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 44 continue to document specific target behaviors. No recommendations regarding tapering of Lexapro were made in reviews of R7's medication regimen. R7's record lacked physician documentation of contraindications for tapering Lexapro. On 12/8/16, at 9:32 a.m. DON confirmed tapering of R7's antidepressant had not been attempted nor had contraindications to tapering been documented. R11 received the antidepressant medications Zoloft (sertraline) and Remeron (mirtazipine) and the record lacked rationale for the use of duplicate therapy. R11's quarterly MDS dated 11/13/16, indicated R11 had diagnoses which included Alzheimer's disease, dementia, anxiety disorder, depression, psychotic disorder and conduct disorder. The MDS indicated R11 had moderate cognitive impairment, required extensive assist of 1 staff for personal hygiene and limited assist of 1 staff for dressing. The MDS indicated staff assessment of R11's mood included the following symptoms: feeling tired or having little energy and poor appetite or overeating. The mood assessment also indicated R11 was short tempered, easily annoyed 2-6 days during the assessment period. The MDS also indicated R11 exhibited no psychosis, wandering, verbal behaviors or other behavior symptoms not directed at others, but had physical behavior symptoms directed toward others and rejection of care 1-3 days during the assessment period. The MDS further indicated R11 received antipsychotic, antidepressant and antianxiety medications daily.	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	12/08/2016

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21535	Continued From page 45 R11's Behavioral Symptoms CAA dated 8/22/16, indicated R11 exhibited numerous long standing behavioral issues which included poor impulse control, confusion, talking and yelling, wandering, swearing, delusions, exit seeking and demands to leave the facility. The CAA indicated at times R11 refused to eat or come out of his room. The CAA also indicated R11 liked the "Twins" games, so staff would see if they could get some of the games on. The CAA futher indicated R11 was on psychotropic medication for mood and behaviors and did take them willingly. R11's Psychotropic Medication Use CAA dated 8/22/16, indicated R11 was on psychotropic medications and had a stay at a psychiatric hospital prior to admission to the facility. The CAA indicated R11 had diagnoses of depression, anxiety, and Alzheimer's disease with behavior and conduct issues. The CAA indicated R11 was on lorazepam, Risperdal, Remeron, Zoloft, and Seroquel as needed and the facility would monitor side effects and effectiveness of the medications. R11's Physician Order Report dated 11/7/16 - 12/7/16, indicated R11 had medication orders that included Remeron (mirtazapine) 15 mg at bedtime for major depressive disorder and sertraline 100 mg once a morning for major depressive disorder. R11's undated Care plan indicated R11 received antipsychotic medication: risperidone, antidepressant medications: Remeron and Zoloft and antianxiety medication: lorazepam with a goal R11 would be prescribed the lowest effective dose of medication. The Care Plan directed staff to assess if R11's behavioral symptoms presented a danger to the resident and/or others,	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 46 intervene as needed, implement a behavior management plan with therapeutic approaches and interventions, attempt non-pharmacological interventions, and monitor R11's behavior, mood and response to medication for effectiveness and adverse reactions. On 12/6/16, at 3:33 p.m. R11 was observed wheeling himself independently via wheelchair in the common area. R11 was well groomed and wearing glasses. R11 transferred independently to a chair in the lounge area and began watching television. No behaviors observed. --At 4:12 p.m. licensed practical nurse (LPN)-A brought R11 his medications. LPN-A's approach was calm and pleasant. R11's response was short and abrupt. LPN-A stated R11 did not like loud noises other than the television, for example did not like loud activities such as piano music. --At 4:13 p.m. AA-A approached R11 and invited him to attend a game activity. R11 refused. --At 4:55 p.m. LPN-A stated the resident had hallucinations at times and stated today he had told her someone "crapped in his bed". Review of Pharmacist's Problem List form identified a pharmacist had reviewed R11's medication regimen monthly since admission. On 11/23/16, the pharmacist indicated R11 received Remeron and sertraline for depression and Risperdal for psychosis. The pharmacist recommended documentation of how the medications were helping with target behaviors. The pharmacist did not request a rationale for the use of duplicate antidepressant therapy. The record lacked physician documentation of a rationale for duplicate antidepressant therapy. On 12/8/16, at 9:36 a.m. DON confirmed there	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21535	Continued From page 47 was no clinical rationale for the use of duplicate antidepressant therapy documented in R11's record. The Psychotropic Medication policy reviewed on 11/2016, indicated the facility would make every effort to comply with state and federal regulations related to the use of psychopharmacological medications to include regular review for continued need, appropriate dosage, side effects, risk and/or benefits. The policy also indicated adequate indications for the use of all psychotropic medication will be listed in residents' plan of care along with MAR [medication administration record]. The policy further indicated gradual dose reduction would be done every 6 months for those residents who received psychotropic medication. If GDR was contraindicated for resident, physician to document clinical reasoning in progress notes every six months. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident's medications are free from unnecessary medications. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		