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. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 7 (L8) (L3) RIVERVIEW HOSPITAL & NURSING HOME (L1)245251 1. Initial 2. Recertification (L4) 323 SOUTH MINNESOTA 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination 861347800 (L6) 56716 (L2)(L5) CROOKSTON, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 (L7)8. Full Survey After Complaint (L9) 05 HHA 13 PTIP 01 Hospital 09 ESRD 22 CLIA 01/24/2017 6. DATE OF SURVEY (L34) 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC (L10) 12 RHC 16 HOSPICE 09/30 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 2 AOA 3 Other 11. LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With And/Or Approved Waivers Of The Following Requirements: From (a): ____ 2. Technical Personnel То (b): Program Requirements Scope of Services Limit Compliance Based On: ___ 3. 24 Hour RN 7. Medical Director 4. 7-Day RN (Rural SNF) 1. Acceptable POC 8. Patient Room Size 12. Total Facility Beds 24 (L18) ___ 5. Life Safety Code ___ 9. Beds/Room 13. Total Certified Beds 24 (L17) B. Not in Compliance with Program Requirements and/or Applied Waivers: (L12)* Code: 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID (L15)1861 (e) (1) or 1861 (j) (1): 24 (L37) (L38) (L39) (L42)(L43)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE Date : 18. STATE SURVEY AGENCY APPROVAL Lyla Burkman, Unit Supervisor 03/20/2017 Mark Weath, Enforcement Specialist (L20) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) RIGHTS ACT: X 1. Facility is Eligible to Participate 3. Both of the Above : Facility is not Eligible (L21) 22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE **VOLUNTARY** INVOLUNTARY 08/01/1982 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L24)(L41)(L25)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal A. Suspension of Admissions: 07-Provider Status Change 00-Active (L44)(L27)B. Rescind Suspension Date: (L45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS

(L31)

(L33)

DETERMINATION APPROVAL

03001

01/31/2017

32. DETERMINATION OF APPROVAL DATE

(L28)

(L32)

31. RO RECEIPT OF CMS-1539



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 Weath

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



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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
245251 _{Y1}	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).

ITE		DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix	F0280	Correction	ID Prefix	F0282		Correction	ID Prefix	F0314		Correction
Reg.#	483.10(c)(2)(i-ii,iv (3),483.21(b)(2)	,v) 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. #		(d)(1)(2)(n)(1)-(3)	Completed	Reg. #	483.45(d)		Completed
LSC		12/30/2016	LSC				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			
REVIEWE		REVIEWED BY (INITIALS) LB/MM	DATE 02/07/2	2017	SIGNATURE OF S		8035		DATE 01/24	1/2017
REVIEWE	D BY	REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOW L 12/8/2016	JP TO SURVEY CO	DMPLETED ON			ANY UNCORRECT				YES	в 🔲 по

POST-CERTIFICATION REVISIT REPORT

	POST-CENTIFICATION REVISIT REPORT											
	R / SUPPLIER CATION NUM			MULTIPLE CONST A. Building 01 -	TRUCTION NURSING HOME	01				DATE O	F REVISIT	
245251		יום		B. Wing	NURSING HUIVIE	01			Y2	1/6/201	7 _{Y3}	
NAME OF	FACILITY		I				STREET ADDRESS, CIT	Y, STATE, ZIP C	ODE			
RIVERVI	EW HOSPIT	ΓAL δ	& NURSIN	G HOME			323 SOUTH MINNESOTA					
							CROOKSTON, MN 5671	6				
program, corrected provision	to show tho I and the dat	se d te su d the	eficiencies ch correct	previously repo ive action was ac	rted on the CMS-25	567, Staten deficiency	and/or Clinical Laborato nent of Deficiencies and should be fully identifie 2567 (prefix codes show	Plan of Corrected using either t	ction, that have he regulation o	r LSC		
ITE	М			DATE	ITEM		DATE	ITEM			DATE	
Y4				Y5	Y4		Y5	Y4			Y5	
ID Prefix				Correction	ID Prefix		Correction	ID Prefix			Correction	
Reg. #	NFPA 101			Completed	Reg. #		Completed	Reg. #			Completed	
LSC	K0345			12/28/2016	LSC			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	
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LSC					LSC			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 _				
REVIEWE	D BY		REVIEWE	D BY	DATE	SIGNATUR	RE OF SURVEYOR	1		DATE		
STATE AGENCY (INITIALS) TL/MM 02/07/2017			365	536		01/0	6/2017					
REVIEWED BY REVIEWED BY DATE TITLE DATE CMS RO (INITIALS)												

12/6/2016

FOLLOWUP TO SURVEY COMPLETED ON

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF

UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

YES NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 54BM Facility ID: 00470

	IAKI I-	TO BE COMIT	EIED DI	THE STAT	E SURVET AGENCI	racinty ID. 00470		
MEDICARE/MEDICAID PROVII (L1) 245251	DER NO.	3. NAME AND AL (L3) RIVERVIEV			NG HOME	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification		
2.STATE VENDOR OR MEDICAID	NO.	(L4) 323 SOUTH	MINNESOT	A		1. Initial 2. Recertification 3. Termination 4. CHOW		
(L2) 861347800		(L5) CROOKSTO	ON, MN		(L6) 56716	5. Validation 6. Complaint 7. On-Site Visit 9. Other		
5. EFFECTIVE DATE CHANGE OF	FOWNERSHIP	7. PROVIDER/SU	PPLIER CATE	GORY	<u>02</u> (L7)			
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 12/0	08/2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30		
11LTC PERIOD OF CERTIFICATION	ON	10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complia	ince With		And/Or Approved Waivers Of	The Following Requirements:		
To (b):		_	equirements		2. Technical Personnel	6. Scope of Services Limit		
		Compliance	e Based On:		3. 24 Hour RN	7. Medical Director		
12 Total Facility Pads	24 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	NF) 8. Patient Room Size		
12. Total Facility Beds 13. Total Certified Beds	24 (L18) 24 (L17)	V D N C	r al p		5. Life Safety Code	9. Beds/Room		
13. Total Certified Beds	24 (L17)	X B. Not in Con Requirements	and/or Applied	-	* Code: B*	(L12)		
14. LTC CERTIFIED BED BREAKD	OOWN				15. FACILITY MEETS			
18 SNF 18/19 SNF	F 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
24					()()			
(L37) (L38)	(L39)	(L42)	(L43)					
(137) (130)	(137)	(2.12)	(E13)					
16. STATE SURVEY AGENCY RE	MARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Debra Vincent, HFE N	IEII	0	01/06/2017	(L19)	Mark Meath	, Enforcement Specialist 01/30/2017 (L20		
PA	ART II - TO BE	COMPLETED I	BY HCFA R	EGIONAL	OFFICE OR SINGLE S			
19. DETERMINATION OF ELIGIB	ILITY		IPLIANCE WIT	TH CIVIL		ncial Solvency (HCFA-2572)		
X 1. Facility is Eligible to	Participate	RIGI	HTS ACT:		 Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Eligib								
	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREE	MENT	26. TERMINATION ACTION	: (L30)		
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	ATE	VOLUNTARY 00	<u>INVOLUNTARY</u>		
08/01/1982					01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	ement 06-Fail to Meet Agreement		
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER		
20. 210 21112. 0101. 21112.		n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
	, , , , , ,		(L44)			00-Active		
(L27)	B. Rescind S	uspension Date:						
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
	(L28)	00001		(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	I OF APPROVA	L DATE				
	(L32)			(L33)	DETERMINATION APP	ROVAL		



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:

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

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

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

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

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

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:

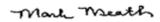
Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division

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

PRINTED: 01/04/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	FIPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
		245251	B. WING _		1	2/08/2016
	PROVIDER OR SUPPLIER EW HOSPITAL & NUF	RSING HOME		STREET ADDRESS, CITY, STATE, Z 323 SOUTH MINNESOTA CROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ΓS	F 0	00		
	as your allegation of Department's acceptoriolled in ePOC, year the bottom of the	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance.				
F 280 SS=D	on-site revisit of you validate that substa regulations has bee your verification. 483.10(c)(2)(i-ii,iv,v)	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with (3),483.21(b)(2) RIGHT TO NNING CARE-REVISE CP	F 2	80		12/30/16
	and implementation	participate in the development on of his or her person-centered ing but not limited to:				
	including the right to be included in the p request meetings a	cipate in the planning process, o identify individuals or roles to planning process, the right to nd the right to request son-centered plan of care.				
	expected goals and amount, frequency,	icipate in establishing the doutcomes of care, the type, and duration of care, and any d to the effectiveness of the				
	(iv) The right to recincluded in the plan	eive the services and/or items of care.				
	(v) The right to see	the care plan, including the				
I ABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE

01/02/201

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.

245251 B. WING	12/08/2016
NAME OF PROVIDER OR SUPPLIER RIVERVIEW HOSPITAL & NURSING HOME STREET ADDRESS, CITY, STATE, ZIP OF 323 SOUTH MINNESOTA CROOKSTON, MN 56716	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF COPREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLÉTION DATE
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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245251	B. WING		12/08/2016	
	PROVIDER OR SUPPLIER EW HOSPITAL & NU	RSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 323 SOUTH MINNESOTA CROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 280	(E) To the extent p the resident and th An explanation mu medical record if the and their resident in not practicable for resident's care plant (F) Other appropria disciplines as deteor as requested by (iii) Reviewed and team after each as comprehensive an assessments. This REQUIREME by: Based on interviewed failed to revise the individualized target antipsychotic medical (R21) reviewed for Finding include:	racticable, the participation of e resident's representative(s). st be included in a resident's ne participation of the resident representative is determined the development of the n. ate staff or professionals in rmined by the resident's needs the resident. revised by the interdisciplinary is sessment, including both the	F 28	Facility timely submits this respondence of correction pursuant to fastate law requirements. This reand plan of correction are not a or an agreement, that a deficient or that the statement of a deficit correctly cited or factually base not to be construed as an admit against the interest of the facility administrator, or any employee	ederal and sponse dmissions, ncy exists ency was d and it is ssion y, the	
	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.			or other individuals who particip drafting or who may be discuss otherwise identified in the same	ed or	
	R21's undated Car antipsychotic medi dementia, delirium	re Plan identified R21 received cation related to Alzheimer's exhibited while in the hospital, and received the antidepressant		The care Plan for R21 was revi Director of Nursing on 12/12/16 plan was then updated to include target behaviors to address resindividualized needs. Written up	i. Care de specific idents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
		245251	B. WING		12/	08/2016
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)			(X5) COMPLETION DATE
F 282 SS=D	be prescribed the I medication. The Cadminister medication monitor resident's medication, docum approaches tried, i management plan non-pharmacologic redirect, folding clocoffee, food or snareview. The Care target behaviors for On 12/8/16, at 8:54 (DON) confirmed Findividualized target Seroquel. The Behavior Monindicated residents altering drug and/o would have target shift. The problem documented in the policy also indicated with any change in resident's ability to or discontinuation of 483.21(b)(3)(ii) SE PERSONS/PER C	30/16) with a goal R21 would owest effective dose of are Plan directed staff to tions Seroquel and Celexa, behavior and response to tent resident behavior and mplement a behavior as needed, attempt cal approaches such as 1:1, othes, walk, movie, game, ck and pharmacy consultant Plan lacked individualized or the use of Seroquel. If a.m. the director of nursing R21's care plan did not include the behaviors for the use of seroquel of the toring Policy dated 11/16, who received a behavior or exhibited negative behaviors behaviors would also be resident's plan of care. The did this information was updated behavior, staff approach, be redirected and the addition of a psychotropic medication. RVICES BY QUALIFIED ARE PLAN	F 2	provided in communication boo 12/13/16 for all staff to review. 12/12/16-12/13/16 all care plar reviewed and target behaviors identified for all residents. As of 12/30/16 all residents wil target behaviors identified on a and included into the written places to care plan will be reviewed to assure proper conference of target behavior identification will be completed monthly for consecutive compliance. Additionally addits will be performed if deer necessary by interdisciplinary the Audit finding will be discussed IDT meetings as well as quarted meetings.	s were were have dmission an of care. ewed at needed. ed by DON ompliance . Audits months of ional ned eam (IDT). at weekly	1/1/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245251	B. WING		12/0	08/2016	
NAME OF	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP			
RIVERVI	EW HOSPITAL & NU	JRSING HOME		323 SOUTH MINNESOTA CROOKSTON, MN 56716			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 282	care. This REQUIREM by: Based on observereview the facility for 1 of 1 (R10) re positioning/toiletir to ensure behavious 2 of 2 clients (R5, medications. R10's Care Planterequired extensive bed mobility, transplanted indicated R1 and was always in directed staff to devery two hours. The current nursi assignment sheet be toileted every stated. On 12/7/16, at 7:2 in bed fully dressed had to find some of the Geri-chair with NA-B and NA-A with from the bed with	page 4 each resident's written plan of ENT is not met as evidenced ration, interview and record failed to provide repositioning resident observed for ring. In addition, the facility failed for monitoring was completed for revised 9/22/16, indicated R10 revised 9/22/16, indicated	F 2	,	of occurrence in incontinence in not being as assessed by o evidence of ak and is provided on and written communication 12/8/16 DON behavior R13. On navior sheets and R13 to mentation on plans were hence and dentified. nitoring sheets wide on 1/1/17 avior ducation in 12/12/16 ance and		
	On 12/7/16, at 11 wheel R10 who w R10's room. NA-Achair since before	:15 p.m. NA-A was observed to vas sitting in the geri-chair into A stated R10 had been in the breakfast and had not been necked for incontinence since		All residents are assessed annually, and as needed pobladder assessment and tistest for need of incontinent repositioning needs. Resident bladder continence lev	er Bowel and ssue tolerance ce care and dents bowel		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245251	B. WING			12/0	08/2016	
	PROVIDER OR SUPPLIE			32	TREET ADDRESS, CITY, STATE, ZIP CODE 23 SOUTH MINNESOTA ROOKSTON, MN 56716			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 282	and NA-C transfer provided incontine be incontinent of the buttock area is and the right thigh from the elastic of stated normally Rafter breakfast but R10 attend an action R10 had been up repositioning/toile forty-five minutes. On 12/7/16 at 12: not repositioned cover 3 hours. Na-activities. On 12/7/16, at 2: (DON) stated R10 provide toileting cover 3 hours. The DON follow the resident staff could have put then taken R10 to the Care Plan point of care would individual resident resident's expectation of care would individual resident resident's expectation of care Plan. R5 received antip	l out of bed. At that time NA-A rred R10 to the bed and ence care. R10 was observed to urine. R10's skin was intact but had red imprints from the brief in area had a bright red mark in the disposable brief. NA-A 10 is assisted back to bed right it activity staff had requested tivity program. NA-A confirmed in the chair without ting for three hours and in the chair without ting for three hours and in the chair without ting for three hours and in the chair without ting for three hours and in the chair without ting for three hours and in the chair without to be stated they took R10 to in the director of nursing is plan of care directed staff to the care plan. The DON added provided incontinence care and	F 2	282	on care plan to reflect their individual needs. As of 12/30/16 all residents have target behaviors identified on admission and included into the writplan of care. These individualized behaviors will then be documented shift by staff. Random audits will be performed by or designee to assure proper care prompliance regarding repositioning incontinence care, as well as documentation of specific target behaviors. Audits will be completed times in first 30 days. Additional auwill be performed if deemed necess IDT. Audit finding will be discussed weekly IDT meetings as well as quark QA meetings.	will tten on q y DON blan and d 14 idits sary by		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		245251	B. WING	j	12	/08/2016		
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, 323 SOUTH MINNESOTA CROOKSTON, MN 56716				
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F 282	record lacked mobehaviors. R5's Physician O 11/7/16-12/7/16, ipsychosis (lack of anxiety. The report of the received antipsyche of the received antipsych of the received antiany items. The care properly and resident's behaviors. R13 received antiany items of the received antiany items. The care properly items of the received antiany items. R13 received antiany items of the received antipsychosis (lack of a gitation. The report of the received antipsych of	rder Report dated ndicated R5 had diagnoses of f contact with reality), and out further identified the ations of alprazolam (antianxiety Seroquel (antipsychotic ated 12/5/16, indicated R5 shotic and antianxiety libited behaviors of irritability, slamming walker against the anoia of others stealing her olan further directed staff to a objectively document the ors. I'd lacked evidence of a objectively documenting R5's ipsychotic (Seroquel) and zolam) medications. The clinical onitoring of individualized target or other steality), and out further identified physician dications of Alprazolam quetiapine (Seroquel)	F 2	282				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245251	B. WING		12/	08/2016	
	PROVIDER OR SUPPLIER EW HOSPITAL & NUI	RSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 323 SOUTH MINNESOTA CROOKSTON, MN 56716	·		
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F 282	behaviors. On 12/8/16, at 9:00 (DON) verified spe and R13 were not the care plan.	a.m. the director of nursing cific target behaviors for R5 being monitored as directed by	F 2			40/00/40	
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO		F3	12/7/16 DON was notified of oc of extended length between reproperties of the control of the con	ositioning essed by	12/30/16	
	assistance. Findings include: R10 was not provide	every two hour repositioning ded repositioning on 12/7/16 I 11:15 a.m. (three hours and		breakdown as skin was pink and blanchable. R10 care plan and sheet updated on 12/12/16 to re for repositioning q 2hrs. Educat provided on 12/7/16 to all staff wand written education was provided communication book for all staff	care flect need ion was vorking ded in		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 314	forty-five minutes; R10's change of signification dated 10/30/16, in cognitive impairm included Alzheime anxiety. The MDS extensive assist of transfer, dressing hygiene. The MD risk for the developing the first for the developing and required a Homobility and also turning. R10's Braden Scarisk dated 10/24/1 risk for developing Tolerance Assess positioning sched R10 was on an exschedule and sho bony prominences. R10's Care Plan required extensive bed mobility, transdirected staff to upplan of care also change R10's briedare did not identification.	•	F 3′	12/12/16-12/13/16 all care reviewed to assure reposit were identified. Education staff meeting on 12/12/16 Proper repositioning. All residents are assessed annually, and as needed p tolerance testing for repositional audition performed on all shifts by lidesignee to assure proper residents. Audits will be conformed on the decrease for one month, then decrease for one month, followed by month. Additional audits a performed if deemed neces audit finding will be discus IDT meetings as well as quiting meetings.	ioning needs provided at regarding on admission, er tissue itioning needs. dits will be DON or repositioning of perpleted 4x/wk ased to 2x/wk 1x/wk for one will be essary by IDT. sed at weekly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245251	B. WING _		12	/08/2016	
	PROVIDER OR SUPPLIER EW HOSPITAL & NUI	RSING HOME		STREET ADDRESS, CITY, STATE, ZIP C 323 SOUTH MINNESOTA CROOKSTON, MN 56716			
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F 314	R10's was to be reassignment sheet is be toileted every 2-stated. On 12/7/16, at 7:20 in bed fully dressed had just been component to help training to the dining room for the dining room the disposable brief. Not assisted back to be activity staff had reprogram. NA-A conchair without repositioned for the disposable for the disposable brief. Not repositioned for the disposable for the disposable disposable brief. Not repositioned for the disposable for the disposable disposable brief. Not repositioned for the disposable for the disposable disposab	did not indicate how often positioned, however, the ndicated all residents were to 3 hours unless otherwise of a.m. R10 was observed to be d. NA-B stated morning cares pleted and she had to find ansfer R10 to the Geri-chair At 7:29 a.m. NA-B and NA-A ransfer R10 from the bed with Geri-chair. R10 was wheeled to	F 31	4			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		245251	B. WING		12/	/08/2016
	PROVIDER OR SUPPLIER EW HOSPITAL & NUI			STREET ADDRESS, CITY, STATE, ZIP CODE 323 SOUTH MINNESOTA CROOKSTON, MN 56716	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 314	On 12/7/16, at 2:15 (DON) stated R10' repositioned and to DON verified she eresident care plando go back to bed miss out on activition. The Repositioning, reviewed 11/16, inconstaff and/or repositioned, toilete otherwise indicated assessment. Each comprehensive assassessment and a appropriate time from the resident of the position necess care will be provided wassistance. The position necess care will be provided NA care sheets with each shift report. 483.25(e)(1)-(3) NORESTORE BLADD (e) Incontinence. (1) The facility must continent of bladder receives services a continence unless or becomes such to maintain.	s plan of care was to be pileted every two hours. The expected staff to follow the The DON added if resident's right after breakfast then they es. I toileting, exercise policy dicated resident's dependent quiring staff assistance will be ead every 2-3 hours unless diby their comprehensive resident will have a sessment, analysis of plan of care to determine ames for their need to be with exercise and toileting olicy indicated specific sary to provide individualized end in the care plan and on the chich changes communicated in DOCATHETER, PREVENT UTI, DER Set ensure that resident who is the rand bowel on admission and assistance to maintain his or her clinical condition is that continence is not possible with urinary incontinence, based comprehensive assessment, the	F 31			12/30/16
	to maintain. (2)For a resident w	with urinary incontinence, based comprehensive assessment, the				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		E SURVEY PLETED
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F 315		age 11 enters the facility without an	F 31	5		
	indwelling catheter	is not catheterized unless the ondition demonstrates that				
	indwelling catheter is assessed for ren as possible unless	enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary				
	receives appropriat	is incontinent of bladder te treatment and services to ct infections and to restore extent possible.				
	on the resident's confacility must ensure incontinent of bowe treatment and serv bowel function as p	with fecal incontinence, based omprehensive assessment, the e that a resident who is el receives appropriate ices to restore as much normal possible. NT is not met as evidenced				
	Based on observa review, the facility f repositioning was p (R10) who were at	tion, interview and document failed to ensure timely provided for 1 of 2 residents risk for developing a pressure every two hour repositioning		-12/7/16 DON was notified of extended length between it cares for R10 Resident skin wassessed by DON and found evidence of breakdown as skand blanchable. Education won 12/7/16 to all staff working education was provided in cobook for all staff to review.	ncontinence was to have no kin was pink was provided and written	
	R10 was not provid	ded repositioning on 12/7/16 I 11:15 a.m. (three hours and		12/12/16-12/13/16 all care placeviewed to assure incontine were identified. Education prostaff meeting on 12/12/16 reg	nce needs ovided at	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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F 315	R10's change of st dated 10/30/16, ind cognitive impairmed included Alzheimed anxiety. The MDS extensive assist of transfer, dressing, hygiene. The MDS risk for the development of the	ratus Minimum Data Set (MDS) dicated R10 had severe ent and diagnoses which discase, dementia, and also indicated R10 required two people for bed mobility, toilet use and personal further indicated R10 was at oment of pressure ulcers. Intinence and Indwelling a Assessment (CAA) dated dient on staff for assistance. The old functional incontinence dient on staff for assistance. The old functional incontinence dient and toileting. The plan of the check and change R10 is ars. By assistant (NA) group indicated all residents were to dient and she had to find ansfer R10 to the Geri-chair At 7:29 a.m. NA-B and NA-A ransfer R10 from the bed with Geri-chair. R10 was wheeled to dient dient dient. R10 was wheeled to dient dient. R10 was wheeled to dient dient dient. R10 was wheeled to dient dient dient. R10 was wheeled to	F3	315	All residents are assessed on admi annually, and as needed per Bowel bladder assessment for need of incontinence care. Residents bot bladder continence level is updated care plan to reflect their individual resigned on all shifts by DON or designed to assure proper care placompliance regarding incontinence Audits will be completed 4x/wk for month, then decreased to 2x/wk for month, followed by 1x/wk for one madditional audits will be performed deemed necessary by IDT. Audit fi will be discussed at weekly IDT me as well as quarterly QA meetings.	wel and l on needs. e n care. one one onth. if nding	

			E SURVEY MPLETED			
		245251	B. WING	<u> </u>	12/	08/2016
	PROVIDER OR SUPPLIEF		;	STREET ADDRESS, CITY, STATE, ZIP CODE 323 SOUTH MINNESOTA CROOKSTON, MN 56716	, . <u></u>	
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F 315	On 12/7/16 at 11:1 wheel R10 in the ONA-A stated R10 in the ONA-A stated R10 in the ONA-A stated R10 in the End or checked for including assisted out of between NA-A and NA-C trilift to the bed and R10 was observed R10's skin was intimprints from the Inhad a bright red in disposable brief. Not assisted back to bactivity staff had reprogram. NA-A conchair without reportive minutes. On 12/7/16 at 12:5 not repositioned for was taken by active program. On 12/7/16, at 2:1 (DON) stated R10 repositioned and the DON verified shere resident care pland do go back to bed miss out on activity. The Repositioning reviewed 11/16, in on staff and/or rerepositioned, toiled otherwise indicate assessment. Each	Is p.m. NA-A was observed to Geri-chair into R10's room. had been up in the chair since R10 had not been repositioned ontinence since R10 was d before breakfast. At that time ansferred R10 with the Hoyer provided incontinence care. It to be incontinent of urine. Fact. The buttock area had reduced and the right thigh area hark from the elastic on the NA-A stated normally R10 was reduced a right after breakfast but requested R10 attend an activity infirmed R10 had been up in the sitioning for three hours and rover 3 hours and stated R10 was prover 3 hours and stated R10 was proved the director of nursing 1.5 p.m. the director of nursing 1.5 p	F 315			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245251	B. WING		12/	08/2016
	PROVIDER OR SUPPLIER EW HOSPITAL & NUF	RSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 323 SOUTH MINNESOTA CROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILITION DEFICIENCY)) BE	(X5) COMPLETION DATE
F 315	appropriate time fra moved, provided wi assistance. The pol information necessicare will be provide	ge 14 plan of care to determine times for their need to be th exercise and toileting licy indicated specific ary to provide individualized d in the care plan and on the n changes communicated in	F 3	15		
F 323 SS=D	483.25(d)(1)(2)(n)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	vironment remains as free rds as is possible; and eccives adequate supervision ices to prevent accidents. e facility must attempt to use tives prior to installing a side or side rail is used, the facility it installation, use, and drails, including but not limited ments. dent for risk of entrapment to installation. s and benefits of bed rails with dent representative and obtain	F3	23		12/30/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	e) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		245251	B. WING			12/0	08/2016
NAME OF F	PROVIDER OR SUPPLIEF	₹		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>	
RIVERVI	EW HOSPITAL & NU	IRSING HOME			23 SOUTH MINNESOTA ROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From passed on observing review, the facility comprehensive faroot cause analys interventions for et (R25) reviewed for Findings included R25's Diagnosis Findings included R25's admission Findicated R25 to the findicated R25's admission Findicated R25's admission Findicated R25 requirencouragement of in room, bed mobindicated R25 requipely only when wassistance of one assistance with to R25 was not stead without human as sit to stand position R25's Fall Care A10/28/16, indicate	page 15 ation, interview, and document failed to complete a lls assessment which included is, to evaluate care plan ifficacy for 1 of 3 residents r falls. Report dated 10/19/16, identified included Alzheimer's disease ght loss. The physician order's twas received on 10/19/16, to	i	323		DN and ualized ission In ded nanges. e IDT eeting d fall nce of ance of esent at e is ecurred from ons are is ecurred from ons are it ons to	
	identified R25's in incontinence, hea impairment, and A indicated R25 had admission and wadepartment with nassessment indicated R25 had admission and wadepartment with nassessment indicated R25's incontinuous inco	ternal risk factors for falling as ring impairment, cognitive Alzheimer's disease. The CAA If fallen at home on the day of as evaluated at the emergency or injuries noted. The ated R25 walked with a wheeled ared steady and one staff to			falls and interventions will be review weekly IDT meetings with detailed detailing conversations surrounding interventions. Falls are then closed DON, with the recommendations githe IDT as well, in order to assure pall interventions are in place. Effect 12/30/16 all falls reports will be review.	ved at notes g fall d by iven by proper tive	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l \		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245251	B. WING			12/0	08/2016
NAME OF F	PROVIDER OR SUPPLIE	२		ST	FREET ADDRESS, CITY, STATE, ZIP CODE		.0.2010
RIVERVI	EW HOSPITAL & NU	JRSING HOME			23 SOUTH MINNESOTA ROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From p	page 16	F 3	323			
F 323	A falls risk assess indicated R25 had represents a high. A therapy admissi therapist (PT) dat fall before admissindicated there we or loss of balance noted R25 ambula (FWW) and used out of chairs and self-cares. The Pservices were ind to monitor R25 for R25's care plan dwas at risk for fall previous falls at h 10/24/16, included ambulate/transfer light in reach at al strength training, training, gait training care plan also indenvironment free identified R25 as bladder and direct hours. The Residents Preserves a high	ment completed 10/24/16, d a score of 9 (10 or higher risk for falls). In screen by a physical ed 10/20/16, identified R25's ion. The screening note ere no reports of unsteadiness in the last 24 hours. The PT ated with a front wheeled walker safe technique getting in and s independent in toileting and roted no skilled therapy icated and nursing to continue resafety due to fall history. In the screening note ere no reports of unsteadiness in the last 24 hours. The PT ated with a front wheeled walker safe technique getting in and s independent in toileting and roted no skilled therapy icated and nursing to continue resafety due to fall history. In the screening in and service at times and ome. The interventions all dated digive verbal reminders not to without assistance, keep call I times, obtain PT consult for toning, positioning, transfering and mobility devices. The icated staff was to provide an of clutter. The care plan being incontinent of bowel and ted staff to toilet R25 every 2-3	F3	323	by charge nurse and then submitted DON within 24 hours to assure the being completed properly and neces information is included. Resident finterventions will be reviewed and conversation documented at weekly meetings. Falls are also tracked an reported upon at quarterly QA meet Audits on documentation will be conducted by administrator or designasure proper compliance for fall follow-up and intervention implementalliness tracking audits will be computative for one month, then decreas 2x/wk for one month, followed by 1 for one month. Additional audits will performed if deemed necessary by interdisciplinary team (IDT). Audit for will be discussed at weekly IDT meas well as quarterly QA meetings.	y are essary alls and y IDT nd tings. gnee to entation. leted ed to x/wk Il be inding	
	11/4/16, at 11:36 p nurse (LPN) noted help. Staff entered on the floor in from coming back from	ogress Notes (PN) written on p.m. by a licensed practical difference resident was yelling out for difference room and observed R25 sitting at of the bed. R25 stated when a the bathroom she fell onto the poget into bed. No injury noted					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE COMP	
		245251	B. WING_		12	/08/2016
	PROVIDER OR SUPPLIER EW HOSPITAL & NU			STREET ADDRESS, CITY, STATE, ZIP 323 SOUTH MINNESOTA CROOKSTON, MN 56716		
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F 323	and neurological to initiated and within instructed on call li assessment compindicated R25 had 90 days with no injidentified were call measure taken to passist with toileting two hours. The carwere not updated. A PN written by LP am rounds staff obbuttocks on the flodark, the bathroom bathroom door was the bathroom and bed. The resident of motion. The PN the arm from a preinitiated. Post fall a LPN indicated R25 last 90 days with n interventions identificated was the room was the bathroom door The assessment noted was the room was the bathroom door The assessment ir prevent further falls light and bathroom resident is in room checks. The care were not updated. The PN from 11/16 registered nurse (Figure 11/16).	ests (neuro checks) were normal limits (WNL). R25 was ght use. The post falls leted by a LPN on 11/4/16, a history of two falls in the last uries. The current interventions light and PT consult. A prevent further falls was to through out the night every e plan and nursing care sheets. N on 11/10/16, noted during 4 is served R25 sitting on her for in her room. The room was a light was on and the shut. R25 stated she went to fell on the floor trying to get into denied pain and had full range indicated R25 had a bruise on vious fall. Neuro checks were assessment dated 11/10/16, by had a a history of 3 falls in the oinjuries. The current fied were to check R25 ght during rounds. The the factor contributing to falls dark due to resident closing when leaving the bathroom. Indicated the measures taken to so were to leave the overhead light on at all times while and continue with routine plan and nursing care sheets.	F 32	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG		TE SURVEY MPLETED	
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	PROVIDER OR SUPPLIER EW HOSPITAL & NU			STREET ADDRESS, CITY, STATE, ZIP 323 SOUTH MINNESOTA CROOKSTON, MN 56716		
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F 323	yelling help me hel fallen out of bed, cherself up Neuro's post falls assessmindicated the curre lights on and call linoted factors contrand the measures was to have lights and nursing care s A PN from 11/22/19 sitting on the floor checking on reside urine, denied pain, stated she was conhistory of bladder ovoiding, vital signs R25 was assisted to the bathroom arbumping head. The Interventions were additional intervent to her wall." A comwas not completed evaluate current in The PN dated 11/2 noted fall follow up room with walker, the night, bed alarmast falls. A PN dated 12/1/10 sitting on the floor buttocks with feet of the bed, resident for the textremities, no in the second	p me. She stated she had rawled to the chair and gotten started no pain or injuries. The ent dated 11/16/16, by the RN nt interventions identified were ght in place. The assessment ibuting to falls was confusion taken to prevent further falls on at all times. The care plan heets were not updated. 6, by a LPN noted R25 was at 4:07 a.m. when staff was ent. R25 was incontinent of had shoes and brief off. R25 ming from the bathroom, had a dribbling per and post bathroom and neuro checks monitored. In dambulated well. R25 denied ere were no areas of concern. In place from prior falls tion added "use call light added prehensive falls assessment to evaluate risk factors or	F 32	23		

NAME OF PROVIDER OR SUPPLIER RIVERVIEW HOSPITAL & NURSING HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 323 SOUTH MINNESOTA CROOKSTON, MN 56716 D PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTION SHOULD BE COME TO THE APPROPRIATE)		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE					323 SOUTH MINNESOTA		
DEFICIENCY)	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE
F 323 Continued From page 19 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 alot. 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	F 323	assessment was refactors or evaluated On 12/6/16, at 5:15 ambulate independent walking next to her On 12/7/16, at 7:1 in bed sleeping with appeared to be sleetime R25 was inteready to get up an alarm was observed On 12/7/16, at 7:3 A and B stated R2 the night because night to go to the beforgot she went to to go again. NA-B bathroom a lot. On 12/7/16, at 11:3 electronic medical not post falls asserted on 11/22/16, at LPN's may not alwassessment even RN-A was not awadid not know who R25's PN's and stated that time RN-A electronic record to alert staff when geron on 12/7/16, at 2:43 (DON) stated the best of the state of the staff when geron on 12/7/16, at 2:43 (DON) stated the staff was not away the staff when geron on 12/7/16, at 2:43 (DON) stated the staff was not away the staff when geron on 12/7/16, at 2:43 (DON) stated the staff was not away the staff when geron on 12/7/16, at 2:43 (DON) stated the staff was not away the staff when geron on 12/7/16, at 2:43 (DON) stated the staff was not away	ot completed to evaluate risk current interventions. 5 p.m. R25 was observed to dently using a FWW with staff to the dining room. 7 a.m. R25 was observed to be ha FWW next to her bed. R25 teping until 9:15 a.m. At that reviewed and stated she was not did not want breakfast. A bed and on R25's bed. 1 a.m. nursing assistants (NA)-5 had a clip bed alarm during she got up a lot during the athroom. NA-B stated R25 the bathroom and then wants added R25 wants to go to the assential completed after R25 and 12/1/16. RN-A stated the ays think to complete that if they have done it in the past. The R25 had a bed alarm and nitiated it. RN-A reviewed ated it was started on 12/1/16. Applicated R25's care plan in the pread "Bed alarm on bed to titing up."	F 33	23		

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		245251	B. WING		12/	/08/2016	
NAME OF PROVIDER OR SUPPLIER RIVERVIEW HOSPITAL & NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	IDT meetings but s discussion or the in On 12/8/16, at 9:00 there were no comp R25's falls from 11/ evaluate the care p interventions were care plan was not unew interventions a plan. The DON add was the only nurse time to complete th The Falls policy revresidents who expecomprehensive asswithin 24 hours. The updated if indicated time of the fall will gand chart according interventions as dethen data is gathere notified of the need assessment. 483.45(d) DRUG RUNNECESSARY DICTURE (d) Unnecessary Dranger gimen must drugs. An unnecessused— (1) In excessive dos therapy); or	ere always discussed during he did not document the terventions. a.m. the DON confirmed prehensive fall assessments of 22/16, and 12/1/16, to lan and determine if effective. The DON verified the updated and there were no udded since R25's initial care led there were times when she and did not always have the e paper work. Tiewed on 11/16, indicated trience a fall will have a resident's care plan will be a sessment following the fall the resident's care plan will be a sessment information listed belowedly and activate further the emed necessary. If an LPN, and the oncoming RN is for a comprehensive EGIMEN IS FREE FROM RUGS Tugs-General. Each resident's be free from unnecessary stary drug is any drug when see (including duplicate drug)	F 3.			12/30/16	
	(2) For excessive d	urauori, or					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245251			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WING		12/			
NAME OF PROVIDER OR SUPPLIER RIVERVIEW HOSPITAL & NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 323 SOUTH MINNESOTA CROOKSTON, MN 56716				
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F 329	(3) Without adequal (4) Without adequal (5) In the presence which indicate the discontinued; or (6) Any combinating paragraphs (d)(1) This REQUIREM by: Based on observative the facility antidepressant mandidepressant mandidepressant material for dupwas documented reviewed for unnessity include: R21 received antiand the record lact attempt to or continued to medication. R21's Resident Findicated R21 had	page 21 uate monitoring; or uate indications for its use; or ue of adverse consequences e dose should be reduced or ons of the reasons stated in through (5) of this section. ENT is not met as evidenced ation, interview and document failed to ensure tapering of edications was attempted or to tapering were documented s (R21, R7) and failed to ensure olicative antidepressant therapy for 1 of 5 residents (R11) ecessary medications. depressant medication (Celexa) cked documentation of an traindication of tapering the ace Sheet dated 12/7/16, d diagnoses which included ers, depressive episodes, and	F 3	,	egarding (GDR). ddress with ys and e. R11 ted on ntal health oic licative bintment was ng with nuary of		
	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			found that no gradual dose re were missed for any other res this time, nor was duplicative rationales missed. Resident medication reduction monitored by DON for proper	idents at therapy ns will be		

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		245251	B. WING		12/08/2016		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	included the following pleasure in doing the staying asleep or selecting tired or having the assessment per R21 exhibited no programmer of care on 1-3 days. The MDS futher incomplete and antipsychotic and adaily. R21's Behavioral Selection Assessment (CAA) had Alzheimer's distroughout the day behaviors included The physician had antidepressant Celection helped greatly. R21's whereabouts assure safety and pothers. The CAA alterial R21's Psychotropic 10/16/16, indicated due to the use of Secondary son stated R21 was and irritable. R21's hospitalization. Secondary to R21's Physician Or 12/7/16, indicated for R21'	Ing symptoms: little interest or nings and trouble falling or leeping too much 2-6 days and ng little energy 7-11 days of riod. The MDS also indicated sychosis, behavioral dering, but exhibited rejection of the assessment period. dicated R21 received antidepressant medications Tymptoms Care Area of dated 10/16/16, indicated R21 sease and wandered and at night. Mood and other sundowning in the afternoons, chosen to help that with the exa (citalopram) which had had been on Seroquel admission, for hallucinations, an eeded to be monitored to be prevent altercations with so indicated R21 was "bossy". The Medication Use CAA dated the care area was triggered eroquel (quetiapine). R21's as significantly more paranoid experienced delirium due to roquel was started on been helpful. The Seroquel streased from 25 milligrams 12.5 mg at bedtime. The Medication orders exa (citalopram) 20 mg once a	F3	329	with current psychotropic medication policy. If recommendations are not addressed by provider during MD in 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 DON. Updated monitoring sheet implemented by DON on 12/29/16 to better track GDR and results. Random audits will be performed be or designee to assure proper compowith gradual dose reductions and duplicative therapy documentation. will be completed monthly for 2 quantity of consecutive compliance. Additional audits will be performed if deemed necessary by IDT. Audit finding will discussed at weekly Interdisciplinar (IDT) meetings as well as quarterly Quality Assurance meetings.	bounds by by so as y DON liance Audits arters anal I be by team	

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NAME OF PROVIDER OR SUPPLIER RIVERVIEW HOSPITAL & NURSING HOME				323 SC	T ADDRESS, CITY, STATE, ZIP CODE DUTH MINNESOTA DKSTON, MN 56716	·	
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F 329	antipsychotic medic dementia, delirium sundowning and recelexa (started 1/3 be prescribed the lomedication. The Cadminister medicat monitor resident's be medication, documapproaches tried, in management plan anon-pharmacologic redirect, folding clocoffee, food or snacreview. On 12/7/2016, at 12 to ambulate with as (NA)-A from the din NA-A maintained a and provided cues lounge area. Interactive pleasant. No nobserved. Review of Pharmactidentified a pharma medication regimer pharmacist recommanded documents of the pharmactic pleasant of the pharmactic pha	e Plan identified R21 received cation related to Alzheimer's exhibited while in the hospital, ceived the antidepressant 0/16) with a goal R21 would owest effective dose of are Plan directed staff to ions Seroquel and Celexa, behavior and response to ent resident behavior and mplement a behavior as needed, attempt al approaches such as 1:1, thes, walk, movie, game, ck and pharmacy consultant 2:57 p.m. R21 was observed sist of nursing assistant ing room to the common area. patient and calm approach for R21 to sit in a chair in the ction between NA-A and R21 negative resident behavior sist's Problem List form cist reviewed R21's monthly. On 1/31/16, the nended documentation is and the need to initiate e pharmacist also umentation regarding ide effects of the medication. armacist recommended ors be identified, and address empromising the ability to care	F3	29			

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F 329	F 329 Continued From page 24		F 32	29		
	interventions were recommendations were made in any medication regime. Review of R21's phypresent revealed theorem and the restring Celexa. With medication. I think Seroquel at night a well and I do want months to work. Extrying to decreaseOn 3/11/16, the phythere with be Seroquel and I do currentlyOn 5/6/16, the phythere does with that off it within a few medication.	not enough. No regarding tapering of Celexa subsequent reviews of R21's n. hysician notes from 2/11/16, to be following: hysician indicated R21 seems now with sundowning since e will continue her on that we should continue her on the swell since she is doing quite to give the Celexa a few ventually we could consider hysician indicated: R21 is ehaviors with Celexa and think we should continue these hysician indicated: We are roquel today. We will see how and maybe she can be totally nonths. We will keep her on as it seems to be doing well behaviors are doing fairly well				
		endations regarding tapering for continued use were made				
	nursing (DON) con antidepressant had	8:54 a.m. the director of firmed tapering of R21's I not been attempted nor had be tapering been documented.				
	(Lexapro) and the	tidepressant medication record lacked documentation entraindication of tapering the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER EW HOSPITAL & NUI	RSING HOME		STREET ADDRESS, CITY, STATE, 323 SOUTH MINNESOTA CROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 329	medication. R7's annual MDS of had diagnoses which disease, dementia, disorder, mood disconversion disorded disorder. The MDS cognitive impairmed assistance of 1-2 soliving. The MDS in R7's mood included interest or pleasure or staying asleep, fenergy for 2-6 days. The MDS also indice psychosis, verbal bothers, other behavior sothers, rejection of physical behaviors other 1-3 days durity MDS further indicated and antidepressant R7's Behavioral Sylindicated R7 trigged diagnosis of demendisturbance, explosinard of hearing. The behaviors were charefusal of cares, relattempts to elope, of the CAA also indice provider for behavior management and relationship in the morning, 25 mg at bedtime and Lexical discontinuity and the morning, 25 mg at bedtime and Lexical discontinuity and the morning, 25 mg at bedtime and Lexical discontinuity and the morning, 25 mg at bedtime and Lexical discontinuity and the morning, 25 mg at bedtime and Lexical discontinuity and the morning, 25 mg at bedtime and Lexical discontinuity and the morning, 25 mg at bedtime and Lexical discontinuity and the morning, 25 mg at bedtime and Lexical discontinuity and the morning, 25 mg at bedtime and Lexical discontinuity and the morning, 25 mg at bedtime and Lexical discontinuity and the morning, 25 mg at bedtime and Lexical discontinuity and the morning at	dated 9/18/16, indicated R7 ch included Alzheimer's depression, psychotic order, dissociative and rs, and borderline personality indicated R7 had severe nt and required extensive taff for all activities of daily dicated staff assessment of the following symptoms: little in doing things, trouble falling feeling tired or having little of the assessment period. Cated R7 exhibited no behaviors directed toward vioral symptoms not directed at care or wandering, but had symptoms directed toward ng the assessment period. The ted R7 received antipsychotic than dedications daily. Imptoms CAA dated 9/18/16, red for behavioral problems, intia with behavioral sive behavior, agitation and the CAA indicated R7's carted on every shift and R7 had sistive with cares, had no or pull or knock on exit doors. Fated R7 saw a mental health		329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245251	B. WING			12/	08/2016
	PROVIDER OR SUPPLIER EW HOSPITAL & NUI	RSING HOME		323	REET ADDRESS, CITY, STATE, ZIP CODE B SOUTH MINNESOTA ROOKSTON, MN 56716	<u>,</u>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	9/18/16, indicated I Lexapro and had a behavioral disturbathe medications seeffects. The CAA fubeen trying to reduand R7's behaviors on every shift as not there had been not R7's Physician Ord 12/8/16, indicated I included Lexapro 1 depressive disorder R7's undated Care antipsychotic and a to diagnoses of depand dementia with goal R7 would be produced to a diagnoses of depand dementia with goal R7 would be produced, assess and under the medical staff to administer ordered, assess and under the medical staff to administer ordered, assess and under the medical dentified R7 had to being easily annown symptoms and more sponse to medical identified R7 had to being easily annown swearing, history on ose causing nose object in mouth. The monitor R7's mouth psychiatry as need protect other resident member to assist. Staff to implement interventions such	age 26 R7 was on Seroquel and diagnosis of dementia with inces. The CAA also indicated emed effective without side of the indicated the facility had be the dose of R7's Seroquel of were monitored and charted eded. The CAA indicated change in this area. Ber Report dated 11/8/16 - R7 had medication orders that 0 mg once a day for major rewith a start date of 9/8/09. Plan indicated R7 received antidepressant medication due oression, Alzheimer's disease behavioral disturbance with a prescribed the lowest effective ation. The Care Plan directed Seroquel and Lexapro as and record the effectiveness of an into rand report signs of ion or anticholinergic mitor resident behavior and ation. The Care Plan also arget behaviors of: history of ed, negative statements, find physical aggression, picks bleeds and putting inedible are Care Plan directed staff to an, provide appointments with ed, if R7 becomes physical, ents and get another staff. The Care Plan also directed anon-pharmacological as providing a doll to hold and maintaining a calm.	F3	229			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		245251	B. WING _		12	/08/2016
	PROVIDER OR SUPPLIER EW HOSPITAL & NU			STREET ADDRESS, CITY, STATE, ZIP CODE 323 SOUTH MINNESOTA CROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329	environment and a On 12/6/16, at 4:38 participating in a braide (AA)-B assiste participate in the gwere calm and pleactivity, no behavior on 12/7/16, at 7:16 and dressed and and the use of a wambulated to the cin a recliner. No behaviors since de 8/30/16, the pharma continue to docum No recommendation of the contraindications from 12/8/16, at 9:32 of R7's antidepression had contraindications from 12/8/16, at 9:32 of R7's antidepression had contraindications from the contraindication of the contraindication of R11 received the at Zoloft (sertraline) at 2.5 cm.	pproach to resident 5 p.m. R7 was observed ean bag toss activity. Activity ed and encouraged R7 to ame. AA-B and R7 interactions asant. R7 was engaged in the ors observed. 6 a.m. R7 was observed up ambulating in the hall with NA-A alker and gait belt. R7	F 32	9		

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245251	B. WING _		12	/08/2016
	PROVIDER OR SUPPLIER EW HOSPITAL & NU			STREET ADDRESS, CITY, STATE, ZIP (323 SOUTH MINNESOTA CROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 329	R11 had diagnosed disease, demential psychotic disorder MDS indicated R11 impairment, require for personal hygier for dressing. The Massessment of R11 symptoms: feeling poor appetite or ovassessment also in tempered, easily a assessment period exhibited no psychobehaviors or other directed at others, symptoms directed at others, symptoms directed care 1-3 days during MDS further indicated R11 exhibehavioral issues and control, confusion, swearing, delusion leave the facility. The fused to eat or coalso indicated R11 staff would see if the games on. The CA psychotropic medicand did take them	OS dated 11/13/16, indicated is which included Alzheimer's anxiety disorder, depression, and conduct disorder. The 1 had moderate cognitive ed extensive assist of 1 staff ine and limited assist of 1 staff in included the following it in included the following it in included in included indicated R11 was short in included poor indicated R11 osis, wandering, verbal behavior symptoms not but had physical behavior in included behavior in included antipsychotic, in included poor impulse it included poor impulse it included poor impulse it included poor impulse it included poor in included poor in included poor in included poor in included included at times R11 on included included at times R11 on included included at times R11 on included included in included	F 32	9		
	8/22/16, indicated	R11 was on psychotropic ad a stay at a psychiatric				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245251	B. WING		12	/08/2016	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, 323 SOUTH MINNESOTA CROOKSTON, MN 56716	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 329	indicated R11 had anxiety, and Alzh and conduct issu on lorazepam, Ri Seroquel as need side effects and extended R11's Physician C12/7/16, indicated included Remero bedtime for majo sertraline 100 mg depressive disord	Idmission to the facility. The CAA diagnoses of depression, eimer's disease with behavior es. The CAA indicated R11 was sperdal, Remeron, Zoloft, and ded and the facility would monitor effectiveness of the medications. Order Report dated 11/7/16 - di R11 had medication orders that in (mirtazapine) 15 mg at it depressive disorder and gionce a morning for major	F3	329			
	antipsychotic merantidepressant mand antianxiety merantides of medicatic to assess if R11's presented a dangintervene as need management pla and interventions, and and response to adverse reactions	dication: risperidone, nedications: Remeron and Zoloft nedication: lorazepam with a goal escribed the lowest effective on. The Care Plan directed staff is behavioral symptoms ger to the resident and/or others, ded, implement a behavior in with therapeutic approaches , attempt non-pharmacological dimonitor R11's behavior, mood medication for effectiveness and					
	wheeling himself the common area wearing glasses. to a chair in the lo television. No bel At 4:12 p.m. lice brought R11 his r	independently via wheelchair in a. R11 was well groomed and R11 transferred independently bunge area and began watching naviors observed. ensed practical nurse (LPN)-A medications. LPN-A's approach easant. R11's response was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245251	B. WING			12/	08/2016
	PROVIDER OR SUPPLIER EW HOSPITAL & NUI	RSING HOME		323	REET ADDRESS, CITY, STATE, ZIP CODE 3 SOUTH MINNESOTA ROOKSTON, MN 56716	,	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	short and abrupt. L loud noises other the did not like loud accept 4:13 p.m. AA-Ahim to attend a gare-At 4:55 p.m. LPN hallucinations at tint told her someone. The received Remeron and Risperdal for precommended documedications were hard to the pharmacist did use of duplicate and the record. The record lacked rationale for duplicationale for duplicatio	PN-A stated R11 did not like nan the television, for example tivities such as piano music. A approached R11 and invited ne activity. R11 refused. A stated the resident had nes and stated today he had crapped in his bed". Cist's Problem List form acist had reviewed R11's nonthly since admission. The market indicated R11 and sertraline for depression sychosis. The pharmacist umentation of how the nelping with target behaviors. I not request a rationale for the tidepressant therapy. Characteristic problem List form acist indicated R11 and sertraline for depression sychosis. The pharmacist umentation of how the nelping with target behaviors. I not request a rationale for the tidepressant therapy. Characteristic problem List form acist indicated in R11's Medication policy reviewed on the facility would make every he state and federal regulations of psychopharmacological under regular review for propriate dosage, side effects, and the policy also indicated	F3	29			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245251	B. WING		12	/08/2016	
	PROVIDER OR SUPPLIER EW HOSPITAL & NUF	RSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 323 SOUTH MINNESOTA CROOKSTON, MN 56716	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE	
F 329	every 6 months for psychotropic medic contraindicated for	ose reduction would be done those residents who received	F 3	329			
F 428 SS=D	•	DRUG REGIMEN REVIEW, LAR, ACT ON	F 4	128		12/31/16	
	c) Drug Regimen R	Review					
		en of each resident must be nce a month by a licensed					
	brain activities asso and behavior. The	drug is any drug that affects ociated with mental processes se drugs include, but are not the following categories:					
	(i) Anti-psychotic;(ii) Anti-depressant(iii) Anti-anxiety; an(iv) Hypnotic.						
	to the attending phy facility's medical dir	must report any irregularities ysician and the rector and director of nursing, must be acted upon.					
	drug that meets the	ude, but are not limited to, any criteria set forth in paragraph or an unnecessary drug.					
	during this review n separate, written re	s noted by the pharmacist nust be documented on a port that is sent to the and the facility's medical					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245251	B. WING		12/	08/2016	
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP 323 SOUTH MINNESOTA CROOKSTON, MN 56716			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 428	minimum, the resi and the irregularity (iii) The attending resident's medical irregularity has be action has been to be no change in the physician should of the resident's medical the resident's medical frames for the difference of the the the theorem of the the the theorem of the the theorem of the theor	or of nursing and lists, at a dent's name, the relevant drug, of the pharmacist identified. physician must document in the record that the identified en reviewed and what, if any, aken to address it. If there is to be medication, the attending document his or her rationale in dical record. In the monthly drug regiments, but are not limited to, time erent steps in the process and coist must take when he or she allarity that requires urgent action	F 4	On 12/27/16 mental health R21 and R7 were contacte need for GDR. Appointme to address with both reside holidays and earliest appoi available. R11 primary phy contacted on 12/8/16 with mental health provider for a psychotropic medications a duplicative therapy docume Appointment was set up for opening with mental health January of 2017 Chart review was complete Pharmacist on 12/30/16 and Recommendations given to DON audited charts on 12/	nd regarding nts scheduled ents after the ntments vsician was orders to see use of and need for entation. r first possible physician in ed by nd o nursing team.		

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		245251	B. WING			12/0	08/2016
NAME OF F	PROVIDER OR SUPPLIER			Sī	TREET ADDRESS, CITY, STATE, ZIP CODE		
DIVEDVII	EW HOCDITAL & MIL	DOING HOME		32	23 SOUTH MINNESOTA		
RIVERVI	EW HOSPITAL & NU	RSING HOME		С	ROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	indicated R21 had delusional disorde Alzheimer's disease R21's annual Minir 10/16/16, indicated impairment. The Mof R21's mood inclittle interest or ple trouble falling or st much 2-6 days and energy 7-11 days of MDS also indicated behavioral symptor ejection of care of period. The MDS antipsychotic and adaily. R21's Behavioral State Assessment (CAA had Alzheimer's dithroughout the day behaviors included The physician optoantidepressant Cehelped greatly. R2 (quetiapine) since R21's whereabouts assure safety and others. The CAA ara R21's Psychotropic 10/16/16, indicated due to the use of State R21's Psychotropic 10/16/16, indicated due to the use of St	diagnoses which included rs, depressive episodes, and	F 4	.28	found that no gradual dose reduction were missed for any other residents this time, nor were duplicative there rationales missed. The consultant pharmacist shall resolute for physician progress notes and Michanges. If the pharmacist finds the during the first year an anti-psycholomedication is started that two attems Gradual Dose Reduction (GDR) has been done, the pharmacist shall writh the pharmacy tab to the physician to GDR needs to be attempted or the why not must be documented in a physician progress note. If such G not attempted and the physician has written a response either in the pharmacist pharmacist shall notify no must fax to the physician the pharmacist request for a GDR. The resident resident for the resident shall be further documented in the resident shall be further documented in the resident shall be attempted, nursing must contact the physician inform them of the F429 tag and as GDR should be attempted. Whether or no, the physician must address to issue in a progress note to be placed the resident chart. Random audits will be performed by Pharmacy Director to assure proper.	view of chart AR at ic apts at ve not ite in that a reason DR is sonot rmacy of the ursing The bal, to and k if a er yes his ed in	
	and irritable. R21 e hospitalization. Se	experienced delirium due to roquel was started on 10/30/15, iful. The Seroquel dose had			compliance with gradual dose reductions. Audit finding will be disc at quarterly QA meetings.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245251	B. WING_		12	/08/2016
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CO 323 SOUTH MINNESOTA CROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 428	been decreased fridaily to 12.5 mg at R21's Physician C 12/7/16, indicated which included Cemorning for depre On 12/7/16, at 12: ambulate with assiftom the dining ronnegative resident Review of Pharmal identified a pharm medication regime pharmacist recommended doeffectiveness and On 2/24/16, the phappropriate behave were compromising addressed and whinterventions were made in any medication regime Review of R21's present revealed to recommendations arationale for continuon on 12/8/16, at 8:5 (DON) confirmed antidepressant has	or 25 milligrams (mg) twice to bedtime. Order Report dated 11/7/16 - R21 had medication orders elexa (citalopram) 20 mg once a ssive episodes. 57 p.m. R21 was observed to dist of nursing assistant (NA)-A come to the common area. No behavior observed. Acist's Problem List form acist reviewed R21's en monthly. On 1/31/16, the mended documentation are and the need to initiate the pharmacist also cumentation regarding side effects of the medication. The macist recommended from the ability to care for R21 being t	F 42	28		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		245251	B. WING _		12	/08/2016
	PROVIDER OR SUPPLIER EW HOSPITAL & NUF	RSING HOME		STREET ADDRESS, CITY, STATE, ZIP CO 323 SOUTH MINNESOTA CROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 428	he would have exphave identified irreg for tapering of anticomes of tapering of anticomes of tapering of tapering of tapering of contraindication to antidepressant meconfirmed it had not the pharmacist lacked documentate contraindication of the pharmacist lacked d	6 a.m. the administrator stated ected the pharmacist would gularities related to the need depressant medication for R21. 18 a.m. the consultant she would have expected the r documentation of a tapering to R21's dication be identified and of been identified. 18 pressant medication (Lexapro) to failed to identify the recordition of an attempt or tapering the medication. 18 deted 9/18/16, indicated R7 ch included Alzheimer's depression, psychotic order, dissociative and rs, and borderline personality indicated R7 had severe nt. The MDS indicated staff is mood included the following terest or pleasure in doing agor staying asleep, feeling energy for 2-6 days of the late. The MDS also indicated R7 osis, verbal behaviors directed er behavioral symptoms not rejection of care or wandering, ehavior symptoms directed any during the assessment further indicated R7 received	F 42	8		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	, ,	TE SURVEY MPLETED
		245251	B. WING _		12	/08/2016
	PROVIDER OR SUPPLIER EW HOSPITAL & NUI	RSING HOME		STREET ADDRESS, CITY, STATE, ZIP 323 SOUTH MINNESOTA CROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 428	R7's Behavioral Sy indicated R7 trigge diagnosis of demer disturbance, exploshard of hearing. The behaviors were reficares, had no atter on exit doors. The mental health provimedication managed 12.5 mg in the morand 100 mg at bed morning. R7's Psychotropic 19/18/16, indicated I Lexapro and had a behavioral disturbathe medications seeffects. The CAA fubeen trying to reduand R7's behaviors indicated there had R7's Physician Ord 12/8/16, indicated I included Lexapro 1 depressive disorde On 12/6/16, at 4:35 participating in a been gaged in the action of 12/7/16, at 7:16 and dressed and a and the use of a was behaviors observed.	mptoms CAA dated 9/18/16, red for behavioral problems, ntia with behavioral sive behavior, agitation and the CAA indicated R7's usal of cares, resistive with inpts to elope, or pull or knock CAA also indicated R7 saw a ider for behavioral and ement and received Seroquel ning, 25 mg in the afternoon time and Lexapro 10 mg in the Medication Use CAA dated R7 was on Seroquel and diagnosis of dementia with inces. The CAA also indicated emed effective without side of the dose of R7's Seroquel is were monitored. The CAA is were monitored and major rowith a start date of 9/8/09. See p.m. R7 was observed ean bag toss activity. R7 was vity, no behaviors observed.	F 42	28		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245251	B. WING			12/	08/2016
	PROVIDER OR SUPPLIEF			32	TREET ADDRESS, CITY, STATE, ZIP CODE 23 SOUTH MINNESOTA ROOKSTON, MN 56716	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 428	identified a pharm regimen monthly. recommended to behaviors since do 8/30/16, the pharm continue to docum. No recommendati Lexapro were made regimen. R7's record lacked contraindications of the	acist reviewed R7's medication On 4/26/16, the pharmacist continue to document on ecrease in Seroquel. On nacist recommended to nent specific target behaviors. ons regarding tapering of de in reviews of R7's medication d physician documentation of for tapering Lexapro. 2 a.m. the DON confirmed ntidepressant had not been d contraindications to tapering	F4	128			
	contraindication to antidepressant me confirmed it had n	edication be identified and					
	(sertraline) and Repharmacist failed	depressant medication Zoloft emeron (mirtazipine) and the to identify the record lacked se of duplicate therapy.					
	R11 had diagnose	OS dated 11/13/16, indicated so which included Alzheimer's a, anxiety disorder, depression,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245251	B. WING		12	2/08/2016
	PROVIDER OR SUPPLIER EW HOSPITAL & NU			STREET ADDRESS, CITY, ST 323 SOUTH MINNESOTA CROOKSTON, MN 567	TATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 428	psychotic disorder MDS indicated R1 impairment. The M of R11's mood incl feeling tired or hav appetite or overear also indicated R11 annoyed 2-6 days. The MDS also indipsychosis, wander behavior symptom had physical behavior symptom had physical behavioral issues sessment period R11 received antipantianxiety medicated R11 exhibehavioral issues control, confusion, swearing, delusion leave the facility. Trefused to eat or c futher indicated R1 medication for moothem willingly. R11's Psychotropic 8/22/16, indicated medications and hospital prior to ad indicated R11 had anxiety, and Alzhe and conduct issue on lorazepam, Ris Seroquel as neede	and conduct disorder. The I had moderate cognitive IDS indicated staff assessment uded the following symptoms: ing little energy and poor ting. The mood assessment was short tempered, easily during the assessment period. cated R11 exhibited no ing, verbal behaviors or other s not directed at others, but vior symptoms directed toward n of care 1-3 days during the d. The MDS further indicated sychotic, antidepressant and	F	228		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245251	B. WING			12/	08/2016	
	PROVIDER OR SUPPLIER EW HOSPITAL & NUF	RSING HOME		32	REET ADDRESS, CITY, STATE, ZIP CODE 3 SOUTH MINNESOTA ROOKSTON, MN 56716	, -=		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 428	R11's Physician Or 12/7/16, indicated Fincluded Remeron bedtime for major of sertraline 100 mg of depressive disorde. On 12/6/16, at 3:33 wheeling himself in the common area. behaviors observedAt 4:12 p.m. licen brought R11 his meshort and abruptAt 4:13 p.m. R11 he refusedAt 4:55 p.m. LPN hallucination at time. Review of Pharmacidentified a pharma medication regimer On 11/23/16, the pharmacidentified apharma medications were for the pharmacist did use of duplicative at the record lacked rationale for duplicate antidepre R11's record.	der Report dated 11/7/16 - R11 had medication orders that (mirtazapine) 15 mg at depressive disorder and once a morning for major r. 5 p.m. R11 was observed dependently via wheelchair in R11 was well groomed. No d. sed practical nurse (LPN)-A edications. R11's response was was invited to an activity and -A stated the resident had	F4	-28				

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 any unnecessary medication and physicians are documenting appropriately on medications needing review. F 441 SS=F (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	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
RIVERVIEW HOSPITAL & NURSING HOME RIVERVIEW HOSPITAL & NURSING HOME (24) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIONY MUST BE PRECEDED BY PREEX TAG. (24) ID REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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 441 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, SS=F (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			245251	B. WING			12/	08/2016
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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 dosage, are not prescribed at appropriate dosage, are not prescribed at appropriate dosage, are not prescribed at appropriate gapropriately on medications needing review. F 441 483.80(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 controllling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
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	he would have exphave identified irreg duplicate antidepre On 12/8/16, at 10:1 pharmacist confirm R11's duplicate antirequested a rational continued use and The Pharmacy Correvised 10/2016, in pharmacist would repropriate diagnosappropriate diagnosappropriate dosage unnecessary medic documenting appropriate documenti	ected the pharmacist would gularities related to R11's essant therapy. 8 a.m. the consultant led she should have identified idepressant therapy and ale from the physician for its had not done so. Insultant Agreement policy dicated the consultant eview residents charts monthly ations are prescribed with an sis, are prescribed at e, are not prescribed any eation and physicians are priately on medications (e)(f) INFECTION CONTROL, D, LINENS Intion and control program. Stablish an infection prevention in (IPCP) that must include, at lowing elements: Eventing, identifying, reporting, controlling infections and eases for all residents, staff, and other individuals under a contractual dupon the facility assessmenting to §483.70(e) and following standards (facility assessment					1/2/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245251	B. WING		12	/08/2016	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP 323 SOUTH MINNESOTA CROOKSTON, MN 56716			
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F 441	for the program, valimited to: (i) A system of surpossible community before they can sefacility; (ii) When and to valid communicable discreported; (iii) Standard and to be followed to seful to be followed to seful when the followed to seful to be followed to seful to be followed to seful to be followed to seful to	page 41 ards, policies, and procedures which must include, but are not reveillance designed to identify sicable diseases or infections pread to other persons in the whom possible incidents of sease or infections should be transmission-based precautions prevent spread of infections; w isolation should be used for a g but not limited to: duration of the isolation, the infectious agent or organism that the isolation should be the possible for the resident under the sinces under which the facility ployees with a communicable and skin lesions from direct lents or their food, if direct	F 4	,			
	(vi) The hand hyg by staff involved i (4) A system for r	nit the disease; and liene procedures to be followed in direct resident contact. ecording incidents identified is IPCP and the corrective					

` /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			(X3) DATE SURVE COMPLETED	
		245251	B. WING			12/0	08/2016
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F 441	process, and transpapered of infection. (f) Annual review. annual review of its program, as necess This REQUIREMENT by: Based on observative review the facility fath hand hygiene was proported for the facility surveillance progrative trends of resident in antibiotic. This had residents residing in Findings include: On 12/7/16, at 11:3 control logs were remursing (DON). The which identified the identified, name of which the resident is symptoms were necessity.	nel must handle, store, port linens so as to prevent the The facility will conduct an IPCP and update their sary. NT is not met as evidenced tion, interview and document ailed to ensure appropriate provided for 1 of 1 residents ring a dressing change. In failed to develop an ongoing m to analyze patterns and affections not treated with an the potential to affect all 23	F4	141	At the time of survey, there was monitoring in place for infections that occurred. On 12/7/16 the tracking f was updated to include the tracking symptoms. Prior to this symptoms we monitored and tracked in the reside charts and these would only be place the infection log if an infection was present. On 12/7/16 DON was notific occurrence of improper hand hygier R12. Education was provided immediately on 12/7/16 to all staff we on importance of proper hand hygier Written education was provided in communication book for all staff to read the staff to the staff was provided in the illness/infect log, along with infections. This is in alignment with the updated infections.	form of of vere nts sed in ied of ne for vorking ene. review.	
	organisms, and the prescribed by the p did not contain the illnesses which wer antibiotic. On 12/7/16, at 11:4 infection control pra	type of antibiotic or treatment hysician. However, the logs tracking or trending of any re not being treated with an 5 a.m. the DON, also the actitioner, stated only cribed antibiotics were			prevention policy. It is the policy of RiverView Care Center that proper I hygiene be used every time gloves a removed, whether hands are visibly or not. Education was provided at st meeting on 12/12/16 to assure all st away of the current hand hygiene pound what the expectations are regar compliance.	hand are soiled taff taff are olicy	

AND DUAN OF CORRECTION IN IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		E SURVEY PLETED		
		245251	B. WING		12/0	08/2016
NAME OF	PROVIDER OR SUPPLIER	₹	·	STREET ADDRESS, CITY, STATE, ZIP CO	•	
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	EN HOOF HAL GING	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		CROOKSTON, MN 56716		
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F 441	Continued From p	page 43	F 4	41		
Γ 44 I	tracked. She state established a syst were not treated was reconstructed by the proper hand hygien R12's dressing characteristic proper hand hygien R12's Physician of dementia, malignation of deme	tem to track infections which with antibiotics. monitoring and surveillance of quested and none was provided. ange was not completed with ene. arder's identified the diagnoses gnant neoplasm of cheek m of head, face and neck, and epening into the stomach for the old and medication status. The identified a dressing change to the ube (GT) site: cleanse with the area dry, apply Desitin as ses. Place 4x4 (split gauze site. Make sure GT disc is on	F4	Staff meeting held on 12/12/ was given to staff regarding tracking illnesses as well as hand hygiene after removing Random audits on all shifts was performed by DON or design proper hand hygiene complice Observational hand hygiene completed 4x/wk for one modecreased to 2x/wk	new policy of importance of gloves. will be nee to assure ance. audits will be noth, then month, onth. Audits e conducted re proper tion tracking will be nth, then month, onth. orth. brind if isciplinary be discussed	

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245251	B. WING			12/	08/2016
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F 441	solution and a dry a site area. LPN-A di cleansing gauze. L and dried R12's ab site. R12's abdomi clean and no redde LPN-A removed he washing hands, do applied a clean 4x observed to tape the abdomen and date On 12/7/16, at 9:25 not wash her hand gloves during the F verified hand hygic completed during ton 12/7/16, at 11:5 LPN-A should have utilized hand sanitischange. The facility "Infection policy, reviewed 1/ supplies, remove scomplete hand hygiste area, remove shygiene, don clean	4x4. LPN-A cleansed the GT scarded the soiled 4x4 PN-A obtained a second 4x4 domen surrounding the GT nal GT site was observed to be ened skin was observed. Expressive soiled gloves and, without nned clean gloves. LPN-A to the GT site. LPN-A was ne GT dressing to R12's down the dressing. Sower and the dressing of the dressing change. LPN-A and the dressing change. LPN-A and the dressing change. LPN-A and the dressing change. Sower and the dressing change. Sower and the dressing change of the dressing change of the dressing change. The dressing change of the dressing c	F	141			

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PRINTED: 01/06/2017 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A: BUILDING 01 - NURSING HOME 01 245251 B. WING 12/06/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 323 SOUTH MINNESOTA **RIVERVIEW HOSPITAL & NURSING HOME** CROOKSTON, MN 56716 (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 **FIRE SAFETY** THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE TITLE

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.

If continuation sheet Page 1 of 4

01/02/2017

Electronically Signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NURSING HOME 01			(X3) DATE SURVEY COMPLETED		
	~	245251	B. WING	i		12/06/2016			
NAME OF PROVIDER OR SUPPLIER RIVERVIEW HOSPITAL & NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 323 SOUTH MINNESOTA CROOKSTON, MN 56716						
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K 000	Continued From pand Angela.Kappenm	_	K	000					
		ORRECTION FOR EACH ST INCLUDE ALL OF THE FORMATION:							
	A description of to correct the defi	f what has been, or will be, done ciency.							
	2. The actual, or p	proposed, completion date.							
	responsible for co	or title of the person orrection and monitoring to rence of the deficiency							
20	without a baseme constructed at 2 c building was considetermined to be In 2003 the south additions to and r was determined t construction.	g Home is a 1-story building ent. The building was different times. The original structed in 1974 and was of a Type II(000) construction. wing addition was built with emodeling of the north wing. It to be of a Type V (111)							
	compartments an	e is divided into 2 smoke d is separated from the building by two, 2 hour fire							
	detection through the common space monitored for aut notification and is	fire alarm system with smoke out the corridor system and in ces. The fire alarm system is omatic fire department installed in accordance with ational Fire Alarm Code".							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NURSING HOME 01			SURVEY
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	PROVIDER OR SUPPLIER			32	REET ADDRESS, CITY, STATE, ZIP CODE 3 SOUTH MINNESOTA ROOKSTON, MN 56716		
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K 000	station smoke detat the nurse's stati the rooms. The busprinkler system in NFPA 13 Standard Sprinkler Systems The facility has a census of 23 at the	ns created in 2003 have single ectors installed, with an alarm ion and on the corridor side of illding has an automatic estalled in accordance with difor Installation of Automatic	K	000			
K 345 SS=F	NOT MET as evid NFPA 101 Fire Ala Maintenance Fire Alarm System A fire alarm system accordance with a with the requirement Electric Code, and and Signaling Code	enced by: arm System - Testing and n - Testing and Maintenance in is tested and maintained in an approved program complying ents of NFPA 70, National d NFPA 72, National Fire Alarm de. Records of system tenance and testing are readily	K	345			12/28/16
Á	Based on record facility failed to ve by the Life Safety section 9.6.1.3 an Alarm and Signali 14.3.1. This deficinotification to emergiallure and affect	is not met as evidenced by: review and staff interview the rify the DACT signal as required Code,(LSC) 2012 edition, d NFPA 72, The National Fire ng Code, 2010 edition, table tent condition could delay alarm ergency personnel in case of a all 23 residents and an ount of staff and visitors.			The DACT system shall be tested, least annually, by SIMPLEX that it i operating successfully. The record testing, and the results of successf passing the testing process, will be maintained in the office of the Plant Services Manager at RiverView He and made readily available to the SFire Marshal, upon request.	is I of fully t tealth	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G 01 - Nursing Home 01		TE SURVEY MPLETED	
		245251	B. WING _		12	/06/2016
	PROVIDER OR SUPPLIER EW HOSPITAL & NU					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 345	on 12-06-2016 red revealed the DAC This deficient con-	r between 10:00 am to 1:00 pm cord review and staff interview T signal was not being verified, dition was confirmed by the ator and the Environmental	K 34	5		



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 <u>only a suggestion</u> 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

Riverview Hospital & Nursing Home December 23, 2016 Page 2

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 Meeth

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

PRINTED: 01/31/2017 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00470 12/08/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 323 SOUTH MINNESOTA **RIVERVIEW HOSPITAL & NURSING HOME** CROOKSTON, MN 56716 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****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/inf obul.htm The State licensing orders are delineated on the attached Minnesota

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Electronically Signed

(X6) DATE 01/02/17

54BM11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	COMPLETED
A. BUILDING:	
00470 B. WING	12/08/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CO	DE
RIVERVIEW HOSPITAL & NURSING HOME 323 SOUTH MINNESOTA CROOKSTON, MN 56716	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EAC	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE
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.	

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
		00470		B. WING		12/0	8/2016
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 323 SOUTH MINNESOTA CROOKSTON, MN 56716						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA THERE IS NO REC PLAN OF CORRECT	N WHICH STATES N OF CORRECTI RAL DEFICIENC R ON EACH PAG	ION." THIS IES ONLY. E.	2 000			
2 302	MINNESOTA STAT MN State Statute 1- or related disorder to ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144.	44.6503 Alzheime train EASE OR RELAT ING:	r's disease	2 302			1/2/17
	(a) If a nursing facil Alzheimer's disease or related or segregated or gene care staff and their supervisor care.	disorders, whether aral unit, the facility	in a y's direct				
	(b) Areas of require (1) an explanation of related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shall written or electronic training program, the trained, the frequent topics covered. (d) The facility shall this section.	of Alzheimer's dise activities of daily li with challenging b skills. provide to consur- form a description be categories of er- acy of training, and	ease and iving; pehaviors; mers in n of the mployees I the basic				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00470	B. WING		12/0	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	RSING HOME	TH MINNESC FON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 302	Continued From pa	ge 3	2 302			
	by: Based on interview facility failed to prov	ent is not met as evidenced and document review, the vide the required Alzheimer's		Corrected		
	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:					
		2/1/16. The employee record having received the required J.				
		10/3/16. The employee ence of having received the s training.				
		8/1/16. The employee record having received the required g.				
		8/15/16. The employee ence of having received the s training.				
	administrator indica written or electronic training to their con AD/SSD indicated t	p.m. the activity ce designee (AD/SSD) and ated they had not provided contice regarding Alzheimer's sumers as required. The they had a brochure available umers, however, confirmed the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BOILDING.	7. Bolebilla.		
		00470	B. WING		12/0	8/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RIVERVII	EW HOSPITAL & NUF	RSING HOME	TH MINNESC FON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 302	Continued From pa	ge 4	2 302			
		description of the training equency of the training.				
	(DON) confirmed N	p.m. the director of nursing IA-D, NA-E, NA-F and NA-G the required Alzheimer's				
	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 days	R CORRECTION: Twenty (21)				
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			1/2/17
		omprehensive plan of care I personnel involved in the i.				
	by: Based on observative review the facility fafor 1 of 1 (R10) res	ent is not met as evidenced ion, interview and record alled to provide repositioning ident observed for . In addition, the facility failed		Corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		00470	B. WING		12/0	08/2016
	PROVIDER OR SUPPLIER	SSING HOME 323 SOUT	DRESS, CITY, S TH MINNESO TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	to ensure behavior 2 of 2 clients (R5, F medications. R10's Care Plan reverequired extensive bed mobility, transfer plan indicated R10 and was always incidirected staff to cheevery two hours. The current nursing assignment sheet in be toileted every 2-stated. On 12/7/16, at 7:20 in bed fully dressed had to find someon the Geri-chair with NA-B and NA-A we from the bed with a R10 was wheeled to breakfast. On 12/7/16, at 11:1 wheel R10 who was R10's room. NA-A schair since before be repositioned or che R10 was assisted of and NA-C transferred provided incontinent of ur the buttock area had and the right thigh a from the elastic on stated normally R10.	ge 5 monitoring was completed for R13) reviewed for unnecessary vised 9/22/16, indicated R10 assistance of two staff with ers and toileting. The care had functional incontinence ontinent. The care plan eck and change R10's brief gassistant (NA)group indicated all residents were to 3 hours unless otherwise a.m. R10 was observed to be the NA-B stated at that time she the to help her transfer R10 to the Hoyer lift. At 7:29 a.m. re observed to transfer R10 Hoyer lift to the Geri-chair. The dining room for 5 p.m. NA-A was observed to sitting in the geri-chair into stated R10 had been in the preakfast and had not been cked for incontinence since but of bed. At that time NA-A ed R10 to the bed and for care. R10 was observed to ine. R10's skin was intact but d red imprints from the brief area had a bright red mark the disposable brief. NA-A D is assisted back to bed right activity staff had requested	2 565			

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			5.25.110.			
		00470	B. WING		12/0	8/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	RSING HOME	TH MINNESC TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	R10 attend an active R10 had been up in repositioning/toileting forty-five minutes. On 12/7/16 at 12:50 not repositioned or over 3 hours. NA-Bactivities. On 12/7/16, at 2:15 (DON) stated R10's provide toileting or hours. The DON versure follow the resident of staff could have protein taken R10 to a staff could have protein	of the chair without and for three hours and of p.m. NA-B verified R10 was checked for incontinence for stated they took R10 to a p.m. the director of nursing plan of care directed staff to incontinence care every two erified she expected staff to care plan. The DON added exclivities. Cy, reviewed on 11/16, dent will have a care plan sed as necessary to reflect the status. The policy indicated the be developed by using assessment data and son and customary routine. It qualified individuals would dinterventions/approaches in yehotic (Seroquel) and plam) medications. The clinical toring of individualized target	2 565			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00470		B. WING		12/	08/2016
	PROVIDER OR SUPPLIER EW HOSPITAL & NUF	RSING HOME	323 SOU	DRESS, CITY, S FH MINNESC TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCI / MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 565	R5's Care Plan data received antipsycho medications, exhibit anxiety, swearing, swall/floor and pararitems. The care plate quantitatively and oresident's behaviors. R5's clinical record quantitatively and obehaviors. R13 received antiparation or antianxiety (Alprazorecord lacked monibehaviors. R13's Physician Or 11/7/16-12/7/16, indepsychosis (lack of cagitation. The report orders for the medications, exhibit agitation, paranoia further directed state objectively docume R13's clinical record quantitatively and obehaviors. On 12/8/16, at 9:00 (DON) verified speciand R13 were not be the care plan.	ed 12/5/16, indicate otic and antianxiety ted behaviors of irristamming walker agnoia of others stealing in further directed stablectively documents. lacked evidence of objectively documents of the stealing of individualizations of individualizations of Alprazolaticated R13 had diacontact with reality), of further identified potations of Alprazolatications of Alprazolatication of Alp	tability, lainst the l	2 565			
		or designee could re es and procedures r	eview/ related to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00470		B. WING		12/0	08/2016
NAME OF PROVIDER OR SUPPLIER RIVERVIEW HOSPITAL & NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE CROOKSTON, MN 56716							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 565 2 570	each resident's carreviewed/revised for assessment and assessment and assessment are establish a system monitor for consiste ongoing compliance. TIME PERIOD FOR (21) days.	he importance of folloge plan. Observations or compliance. The questions committee committee compliance committee compliance to audit care plans and timplementation, to	could be ality ould do ensure	2 565			1/2/17
	Plan of Care; Revision care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within the comprehensive by part 4658.0400, This MN Requirement by: Based on interview failed to revise the condividualized targe antipsychotic medicine.	A comprehensive played and revised by arm that includes the at red nurse with respond other appropriate stamined by the resident practicable, with the resident, the resident representative at lease seven days of the revision tassessment subpart 3, item B.	an of tending asibility aff in 's needs, 's legal st vision of required lenced e facility e of idents		Corrected		
	Finding include:						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00470	B. WING		12/	08/2016
_	PROVIDER OR SUPPLIER EW HOSPITAL & NUF	RSING HOME 323 SO	ADDRESS, CITY, S UTH MINNESO (STON, MN 567	TA		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 570	R21's Physician Or 12/7/16, indicated F that included quetia (antipsychotic) 12.5 disorder, and Celex (antidepressant) 20 depressive episode R21's undated Care antipsychotic medic dementia, delirium and sundowning ar Celexa (started 1/3 be prescribed the lomedication. The Ca administer medicat monitor resident's be medication, docum approaches tried, ir management plan a non-pharmacologic redirect, folding clocoffee, food or snar review. The Care F target behaviors for On 12/8/16, at 8:54 (DON) confirmed F individualized targe Seroquel. The Behavior Monitindicated residents altering drug and/or would have target be shift. The problem I documented in the policy also indicated with any change in	der Report dated 11/7/16 - R21 had medication orders apine (Seroquel) omg at bedtime for delusionate (citalopram) omg once a morning for es. Plan identified R21 received eation related to Alzheimer's exhibited while in the hospital did received the antidepressar 0/16) with a goal R21 would exerce Plan directed staff to ions Seroquel and Celexa, behavior and response to ent resident behavior and mplement a behavior	d I, nt			

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AND DIAN OF CODDECTION IDENTIFICATION NUMBER		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
				A. BUILDING.			
		00470		B. WING		12/0	8/2016
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	RSING HOME		TH MINNESO FON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 10		2 570			
	or discontinuation of	of a psychotropic medica	ation.				
	The director of nurs revise policies and plan revision and plan address the importation when there has been resident care plans for compliance. The assurance committee		eview/ are f to ans vised				
2 830	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 1 Adequate and re; General	d	2 830			1/2/17
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident mu e and treatment, persor supervision based on d preferences as identif resident assessment a scribed in parts 4658.04 ing home resident must possible unless there is he attending physician t in in bed or the resident bed.	ied in nd oo and be out a hat the				
	by: Based on observati review, the facility f	ent is not met as evider ion, interview, and docu ailed to complete a s assessment which inc	ment		Corrected		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00470	B. WING		12/	08/2016
	PROVIDER OR SUPPLIER EW HOSPITAL & NUF	SSING HOME 323 SOU	DDRESS, CITY, S TH MINNESC STON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	root cause analysis interventions for eff (R25) reviewed for Findings included: R25's Diagnosis Rediagnoses which in and abnormal weigidentified an order vadmit R25 to the factor R25's admission M10/27/16, indicated impairment, require encouragement or in room, bed mobili indicated R25 requihelp only when wall assistance of one sassistance with tolk R25 was not steady without human assisit to stand position R25's Fall Care Are 10/28/16, indicated admission and had identified R25's interincontinence, hearif impairment, and Alzindicated R25 had fadmission and was department with no assessment indicated walker, gait appears supervise for ambut A falls risk assessment.	eport dated 10/19/16, identified cluded Alzheimer's disease ht loss. The physician order's was received on 10/19/16, to cility. Inimum Data Set (MDS) dated R25 had severe cognitive ed supervision (oversight, cueing) of one staff for walking try and transferring. The MDS ired supervision and set up king in the hallway, extensive etaff for dressing and limited eting. The MDS also indicated to but able to stabilize herself stance when moving from a or when turning around. The Assessment (CAA) dated R25 had fallen before impaired balance. The CAA ernal risk factors for falling as ang impairment, cognitive exheimer's disease. The CAA fallen at home on the day of evaluated at the emergency injuries noted. The ed R25 walked with a wheeled ed steady and one staff to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00470	B. WING		12/	08/2016
	PROVIDER OR SUPPLIER	SSING HOME 323 SOL	DDRESS, CITY, S ITH MINNESO STON, MN 567	TA		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	represents a high ring represents a high ring admission therapist (PT) dated fall before admission indicated there were or loss of balance in noted R25 ambulate (FWW) and used sout of chairs and is self-cares. The PT services were indicated monitor R25 for self-cares at risk for falling previous falls at hor 10/24/16, included ambulate/transfer with light in reach at all the strength training, to training, gait training care plan also indice environment free of identified R25 as be bladder and directed hours. The Residents Programment (LPN) noted help. Staff entered on the floor in front					
	coming back from the floor attempting to go and neurological termitiated and within instructed on call ligusessessment complete.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00470		B. WING		12/0	08/2016
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	SING HOME		TH MINNESC TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCY MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 830	Continued From pa 90 days with no injuidentified were call measure taken to passist with toileting two hours. The care were not updated. A PN written by LPN am rounds staff obstitocks on the floodark, the bathroom bathroom door was the bathroom and for the arm from a previnitiated. Post fall a LPN indicated R25 last 90 days with no interventions identificated was the room was the bathroom door The assessment noted was the room was the bathroom door The assessment intervent further falls light and bathroom resident is in room checks. The care pwere not updated. The PN from 11/16 registered nurse (R hollering, she was syelling help me help fallen out of bed, or herself up Neuro's spost falls assessment indicated the currer lights on and call lights.	iries. The current in light and PT consurevent further falls through out the night plan and nursing a plan and nursing or in her room. The light was on and the shut. R25 stated a light was on and the shut. R25 stated and plan and had a light was on and the shut. R25 stated and plan and had a light was on and the shut. R25 stated and a light was on and the shut. R25 stated and the sessment dated had a light on the current during rounds. The current during rounds. The current during rounds. The factor contribution when leaving the light on at all times and continue with olan and nursing continue. She stated is awled to the chair started no pain or lent dated 11/16/16 at interventions ideal.	alt. A was to ght every care sheets ed during 4 on her room was he she went to ng to get into d full range a bruise on necks were 11/10/16, by 3 falls in the ent R25 The ting to falls nt closing pathroom. res taken to overhead s while routine are sheets y a rd R25 er door he had and gotten injuries. The by the RN ntified were				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	RSING HOME	TH MINNESO FON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 14	2 830			
	and the measures to was to have lights of	buting to falls was confusion aken to prevent further falls on at all times. The care plan neets were not updated.				
	sitting on the floor a checking on resider urine, denied pain, stated she was conhistory of bladder divoiding, vital signs a R25 was assisted to the bathroom and bumping head. The Interventions were additional intervention to her wall." A comp	is, by a LPN noted R25 was at 4:07 a.m. when staff was not. R25 was incontinent of had shoes and brief off. R25 ning from the bathroom, had a ribbling per and post bathroom and neuro checks monitored. It is a monitored with the description of the were no areas of concern. It is place from prior falls on added "use call light added orehensive falls assessment to evaluate risk factors or erventions.				
	noted fall follow up, room with walker, u	6/16, at 8:06 p.m. by LPN R25 remained in and out of p numerous times through out n in place. No injuries from				
	sitting on the floor r buttocks with feet of the bed, resident fu 4 extremities, no in floor with two staff, assessment was no	i, at 4:00 a.m. noted R25 next to bed, sitting on her ut in front of her, back against lly conscious, movement of all juries. Resident assisted off A comprehensive falls of completed to evaluate risk current interventions.				
	T	p.m. R25 was observed to ently using a FWW with staff to the dining room.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00470	B. WING		12/0	8/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	ISING HOME	TH MINNESC TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 15	2 830			
	in bed sleeping with appeared to be sleet time R25 was intervenedly to get up and alarm was observed					
	A and B stated R25 the night because s night to go to the ba forgot she went to t	a.m. nursing assistants (NA)-had a clip bed alarm during he got up a lot during the athroom. NA-B stated R25 he bathroom and then wants dded R25 wants to go to the				
	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."					
	(DON) stated the be intervention after Ra the interdisciplinary DON stated falls we	p.m. the director of nursing ed alarm was added as an 25's falls were discussed in team (IDT) meeting. The ere always discussed during the did not document the terventions.				
	there were no comp R25's falls from 11/2	a.m. the DON confirmed orehensive fall assessments of 22/16, and 12/1/16, to lan and determine if				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY OMPLETED	
		00470	B. WING		12/	08/2016
	PROVIDER OR SUPPLIER	RSING HOME 323 S	T ADDRESS, CITY, OUTH MINNESO OKSTON, MN 56	ATC	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
2 830	interventions were ecare plan was not unew interventions aplan. The DON add was the only nurse time to complete the The Falls policy revresidents who expecomprehensive asswithin 24 hours. The updated if indicated time of the fall will gand chart according interventions as deathen data is gathere notified of the need assessment. SUGGESTED MET director of nursing cand/or revise policie assessment and imfollowing a fall. Eduthe staff. The quality	effective. The DON verified updated and there were no dded since R25's initial carded there were times when and did not always have the	e she e she e e e e e e e e e e e e e e			
	TIME PERIOD OF (21) Days.	CORRECTION: Twenty-one	Э			
2 840	Proper Nursing Car Subp. 2. Criteria fo	or determining adequate and criteria for determining	2 840			1/2/17

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00470	B. WING		12/0	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	RSING HOME	TH MINNESC TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 840	B. Clean skin odors. A bathing place resident's plan of condition requires the must be given a condition resident every two hours, are following each epis [144A.04 Subd. 17] Notwithstanding Mide58.0520, an inconditional condition of the checked according written in the resident attending physician interval longer than if competent, or a fact appointed conservation agent of a resident in writing to waive place determining this introdumented in the Clean linens or clot promptly each time Perineal care included the perineal area. It is keep the bed dry comfort. Special at skin to prevent irritatives of protectors completely covered contact with the resident in the condition of the perineal area.	and freedom from offensive an must be part of each are. A resident whose hat the resident remain in bed implete bath at least every e often as indicated. An at must be checked at least and must receive perineal care ode of incontinence. I. Incontinent residents. Incontinent residents. Incontinent residents in writing any two hours unless the resident, amily member or legally ator, guardian, or health care who is not competent, agrees obysician involvement in erval, and this waiver is resident's care plan.] hing must be provided the bed or clothing is soiled. The bed or clothing is soiled. The sident's tention must be given to the ation. Rubber, plastic, or other must be kept clean, be land not come in direct sident. Soiled linen and moved immediately from	2 840			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00470	B. WING		12/0	8/2016
NAME OF PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 .=,0	0,1010
RIVERVIEW HOSPITAL & NURSING	; H()MF	TH MINNESO TON, MN 56			
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	T BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
ulcer and required every assistance. Findings include: R10 was not provided re from 7:30 a.m. until 11:15 forty-five minutes). R10's change of status M dated 10/30/16, indicated cognitive impairment and included Alzheimer's disc anxiety. The MDS also ir extensive assist of two p transfer, dressing, toilet hygiene. The MDS furth risk for the development R10's Urinary Incontinent Catheter Care Area Asse 10/30/16, indicated R10 and totally dependent on CAA indicated R10 had f	anterview and document to ensure timely led for 1 of 2 residents or developing a pressure who hour repositioning on 12/7/16 5 a.m. (three hours and diagnoses which ease, dementia, and indicated R10 required beople for bed mobility, use and personal interindicated R10 was at a of pressure ulcers. The and Indwelling essment (CAA) dated was always incontinent in staff for assistance. The functional incontinence in the plan of the plan o	2 840	Corrected		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00470	B. WING		12/0	8/2016
_	PROVIDER OR SUPPLIER EW HOSPITAL & NUF	SSING HOME 323 SOU	DDRESS, CITY, S TH MINNESC STON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 840	Continued From pa	ge 19	2 840			
	assignment sheet in be toileted every 2-stated. On 12/7/16, at 7:20 in bed fully dressed had just been compsomeone to help trawith the Hoyer lift. A were observed to tr	g assistant (NA) group ndicated all residents were to 3 hours unless otherwise a.m. R10 was observed to be 1. NA-B stated morning cares oleted and she had to find ansfer R10 to the Geri-chair At 7:29 a.m. NA-B and NA-A ransfer R10 from the bed with teri-chair. R10 was wheeled to breakfast.				
	wheel R10 in the G NA-A stated R10 has before breakfast. Ror checked for inco assisted out of bed NA-A and NA-C trailift to the bed and p R10 was observed R10's skin was inta imprints from the binad a bright red madisposable brief. Nassisted back to be activity staff had recoprogram. NA-A conchair without repositioned for was taken by activity program.	5 p.m. NA-A was observed to eri-chair into R10's room. ad been up in the chair since 10 had not been repositioned ntinence since R10 was before breakfast. At that time insferred R10 with the Hoyer rovided incontinence care. to be incontinent of urine. ct. The buttock area had rediref and the right thigh area ark from the elastic on the A-A stated normally R10 was adright after breakfast but quested R10 attend an activity firmed R10 had been up in the stioning for three hours and to p.m. NA-B verified R10 was a over 3 hours and stated R10 ty staff to attend a morning				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00470	B. WING		12/0	8/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	RSING HOME	TH MINNESC TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 840	repositioned and to DON verified she e resident care plan. do go back to bed r miss out on activitie. The Repositioning, reviewed 11/16, ind on staff and/or req repositioned, toilete otherwise indicated assessment. Each comprehensive assassessment and a appropriate time framoved, provided w assistance. The poinformation necess care will be provide NA care sheets with each shift report. SUGGESTED MET The director of nurs review policies and needed, train staff,	s plan of care was to be ileted every two hours. The xpected staff to follow the The DON added if resident's right after breakfast then they es. toileting, exercise policy licated resident's dependent uiring staff assistance will be ed every 2-3 hours unless by their comprehensive	2 840			
	of urine, receive the	e necessary services and care ode of incontinence.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 905	MN Rule 4658.052	5 Subp. 4 Rehab - Positioning	2 905			1/2/17
		g. Residents must be body alignment. The position				

STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00470	B. WING		12/0	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•	
RIVERV	IEW HOSPITAL & NUF	RSING HOME	H MINNESC FON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 905	of residents unable must be changed a including periods of been put to bed for has documented the hours during this tirthe physician has of the physician physician has of the ph	to change their own position t least every two hours, it time after the resident has the night, unless the physician at repositioning every two me period is unnecessary or redered a different interval. The is not met as evidenced on, interview and document ailed to ensure timely rovided for 1 of 2 residents risk for developing a pressure every two hour repositioning ed repositioning on 12/7/16 of 11:15 a.m. (three hours and also indicated R10 had severe than diagnoses which is disease, dementia, and also indicated R10 required two people for bed mobility, coilet use and personal further indicated R10 was at ment of pressure ulcers. The CAA also indicated R10 required the indicated R10 was at risk due to incontinence, cognitive. The CAA also indicated R10 returned to not staff for bed mobility	2 905	Corrected		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
71112 1 27111	or connection	BERTH TO THOMBETT.	A. BUILDING:			
		00470	B. WING		12/0	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	RSING HOME	TH MINNESO TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 905	Continued From pa	ge 22	2 905			
	mobility and also required a regular schedule of turning.					
	risk dated 10/24/16 risk for developing Tolerance Assessm positioning schedul R10 was on an eve schedule and show bony prominences R10's Care Plan re required extensive bed mobility, transfi directed staff to use plan of care also di change R10's brief care did not identify The current nursing assignment sheet of R10's was to be rep assignment sheet in	e for predicting pressure sore in indicated R10 was at high pressure sores. R10's Tissue tent (observation to determine e) dated 10/28/16, indicated try two hour repositioning red no signs of redness over at the two hour assessment. Vised 9/22/16, indicated R10 assistance of two staff with the ers and toileting. The plan of the rected staff to check and every two hours. The plan of the R10's repositioning needs. In assistant (NA) group did not indicate how often consitioned, however, the indicated all residents were to 3 hours unless otherwise				
	in bed fully dressed had just been comp someone to help tra with the Hoyer lift. A were observed to tr	a.m. R10 was observed to be I. NA-B stated morning cares oleted and she had to find ansfer R10 to the Geri-chair At 7:29 a.m. NA-B and NA-A cansfer R10 from the bed with teri-chair. R10 was wheeled to breakfast.				
	wheel R10 in the G NA-A stated R10 ha	5 p.m. NA-A was observed to eri-chair into R10's room. ad been up in the chair since 10 had not been repositioned				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

A. BUILDING: DOMPLETED	-	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER RIVERVIEW HOSPITAL & NURSING HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)				A. BOILDING.			
RIVERVIEW HOSPITAL & NURSING HOME 323 SOUTH MINNESOTA CROOKSTON, MN 56716 (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)			00470	B. WING		12/0	8/2016
CROOKSTON, MN 56716 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	NAME OF PF	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	RIVERVIE	EW HOSPITAL & NUF	RSING HOME				
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DATE	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
continued From page 23 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 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 atdend an activity program. NA-A confirmed R10 atdend an activity program. NA-A confirmed R10 was not 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 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		or checked for inco assisted out of bed NA-A and NA-C tra lift to the bed and p R10 was observed R10's skin was inta imprints from the binad a bright red madisposable brief. Nassisted back to be activity staff had recording without repositioned for was taken by activity program. NA-A conchair without repositioned for was taken by activity program. On 12/7/16 at 12:50 not repositioned for was taken by activity program. On 12/7/16, at 2:15 (DON) stated R10's repositioned and to DON verified she e resident care plandogo back to bed miss out on activities. The Repositioning, reviewed 11/16, indo no staff and/or require positioned, toilete otherwise indicated assessment. Each comprehensive assassessment and a appropriate trime framoved, provided with assistance. The po	ontinence since R10 was I before breakfast. At that time Insferred R10 with the Hoyer Provided incontinence care. It to be incontinent of urine. Inct. The buttock area had red Prief and the right thigh area Park from the elastic on the A-A stated normally R10 was I red right after breakfast but I quested R10 attend an activity I firmed R10 had been up in the I titioning for three hours and I p.m. NA-B verified R10 was I over 3 hours and stated R10 I ty staff to attend a morning I p.m. the director of nursing I plan of care was to be I to BON added if resident's I pright after breakfast then they I plan after breakfast then they I plan after breakfast then they I plan of care to determine and sessment, analysis of I plan of care to determine and so the care in the care of their need to be I plan of care to determine and so the care of their need to be I plan of care to determine and so the care of their need to be I plan of care to determine and so the care of their need to be I plan of care to determine and so the care of their need to be I plan of care to determine and so the care of their need to be I plan of care to determine and so the care of their need to be I plan of care to determine and so the care of their need to be I plan of care to determine and to illeting I plan of care of their need to be I plan of care to determine and to illeting I plan of care of their need to be I plan of care to determine and to illeting I plan of care of their need to be I plan of care to determine and to illeting I plan of care of their need to be I plan of care to determine and to illeting I plan of care of their need to be I plan of care of their need to be I plan of care to determine and the care of the care	2 905			

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	OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NU		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00470		B. WING		12/0	8/2016
	PROVIDER OR SUPPLIER	ISING HOME	323 SOUT	DRESS, CITY, S TH MINNESC TON, MN 56		•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 905	Continued From particle Care will be provide NA care sheets with each shift report. SUGGESTED MET director of nursing (develop, review, an procedures to ensure repositioning assist need. The DON or auditing system to example of the Care Care Care Care Care Care Care Car	d in the care plan and changes community of the community	TION: The could and the assessed elop an apliance.	2 905			
21390	control program muprocedures which particles and a surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service exprevention and con E. a resident he immunization program defined in part 465 procedures of resident the prevention and	and procedures. The strinclude policies a provide for the follow based on systematic nosocomial infection detection, investigated precautions system mission of infection ducation in infection trol; ealth program includes am, a tuberculosis part care practices to treatment of infection and implement and implement a tuberculosis program infection a tuberculosis program.	e infection and ving: c data ons in ation, and ses; ns to s agents; ding an orogram as and o assist in ons; tation of control	21390			1/2/17

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION :	(X3) DATE COMP	SURVEY PLETED
		00470	B. WING		12/0	8/2016
	PROVIDER OR SUPPLIER EW HOSPITAL & NUF	SSING HOME 323 SOL	ADDRESS, CITY, JTH MINNESO STON, MN 50			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	G. a system for H. a system for H. a system for products which affed disinfectants, antise incontinence product. I. methods for a current standards of the current standard	r reviewing antibiotic use; review and evaluation of ect infection control, such as eptics, gloves, and cts; and maintaining awareness of fractice in infection control. ent is not met as evidenced on, interview and document alled to ensure appropriate provided for 1 of 1 residents ring a dressing change. In failed to develop an ongoing m to analyze patterns and affections not treated with an the potential to affect all 23		Corrected		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
71112 1 27111	or connection	ISENTI IO/MIGINATIONISEM	A. BUILDING:		0011111	
		00470	B. WING		12/0	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	RSING HOME	TH MINNESO TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	Continued From pa	age 26	21390			
	tracked. She state established a syste were not treated wi	d the facilty had not em to track infections which th antibiotics. monitoring and surveillance of				
	•	nested and none was provided. Inge was not completed with ne.				
	of dementia, malign mucosa, neoplasm gastrostomy (an op- introduction of food Physicians orders in the gastrostomy tul- wound cleaner, rub- needed for redness	der's identified the diagnoses nant neoplasm of cheek of head, face and neck, and bening into the stomach for the land medication status. The dentified a dressing change to be (GT) site: cleanse with area dry, apply Desitin as s. Place 4x4 (split gauze ite. Make sure GT disc is on				
	(LPN)-A asked R12 her GT dressing che gathered supplies a next to the bed. LP hands and apply glackages. R12 exp LPN-A removed the GT site with gloved drainage was obsesurrounding the GT abdomen GT site with dressing and si purulent drainage. dressing and, withough the dressing and the dressing an	a.m. licensed practical nurse to lay down on the bed for lange to be done. LPN-A and placed them on the table N-A was observed to wash her losed the GT on her abdomen. At 4 gauze dressing from the hands. Brown/green purulent rived, approximately 1 inch opening on the gauze. R12's was also observed to have ent drainage. LPN-A verified the contained brown/green LPN-A discarded the soiled but washing hands and btained the wound cleanser 4x4. LPN-A cleansed the GT				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00470	B. WING		12/0	8/2016
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
RIVERV	IEW HOSPITAL & NUF	RSING HOME	TH MINNESC TON, MN 56			
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	site area. LPN-A discleansing gauze. LI and dried R12's abdomir clean and no redde LPN-A removed he washing hands, dor applied a clean 4x4 observed to tape th abdomen and dated On 12/7/16, at 9:25 not wash her hands gloves during the R verified hand hygier completed during the On 12/7/16, at 11:5 LPN-A should have utilized hand sanitized hand hand hand hand hand hand hand han	scarded the soiled 4x4 PN-A obtained a second 4x4 domen surrounding the GT hal GT site was observed to be ned skin was observed. It soiled gloves and, without half clean gloves. LPN-A hat to the GT site. LPN-A was e GT dressing to R12's d the dressing. In a.m. LPN-A verified she did stafter removing her soiled have been he dressing change. LPN-A he should have been he dressing change. Sa.m. the DON verified has washed her hands or at least her during R12's dressing has Control-Dressing Change has the did staff to obtain holled dressing, remove gloves, hiene, reglove, cleanse wound holled gloves, provide hand hand gloves, apply medication (if han dressing, remove gloves hygiene. THOD OF CORRECTION: hing (DON) and/or designee his policies, provide education has policies and	21390			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00470	B. WING		12/0	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE	1 - 1 - 1 - 1	0,1010
		323 SOUT	H MINNESO			
RIVERVI	EW HOSPITAL & NUF	CROOKS1	TON, MN 56	716		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21530	Continued From pa	ge 28	21530			
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review		21530			1/2/17
	reviewed at least me currently licensed by This review must be Appendix N of the Surveyor Procedure Requirements in Lot the Department of I Health Care Finance This standard is in available through the system. It is not sue B. The pharma irregularities to the and the attending period must be acted upor physician visit, or sue pharmacist. For purpon' means the acreport and the signification of nursing services C. If the attend with the pharmacist not provide adequate pharmacist believes being adversely affer the matter to the attending physician. If the medical direct physician does not must be referred for assessment and as by part 4658.0070. The medical direct control of the medical dir	en of each resident must be onthly by a pharmacist y the Board of Pharmacy. It done in accordance with State Operations Manual, as for Pharmaceutical Service ong-Term Care, published by Health and Human Services, ing Administration, April 1992. Corporated by reference. It is the Minitex interlibrary loan bject to frequent change. Coist must report any director of nursing services hysician, and these reports in by the time of the next coner, if indicated by the proses of this part, "acted coceptance or rejection of the ing or initialing by the director and the attending physician. In ing physician does not concurts recommendation, or does the justification, and the sthe resident's quality of life is exted, the pharmacist must he medical director for review for is not the attending edical director determines that coin does not have adequate order and if the attending change the order, the matter is review to the quality surance committee required. If the attending physician is or, the consulting pharmacist er directly to the quality				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION :	(X3) DATE COMP	SURVEY LETED
		00470	B. WING		12/0	8/2016
	PROVIDER OR SUPPLIER EW HOSPITAL & NUF	SSING HOME 323 SOU	DDRESS, CITY, THE MINNESCENTION, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	assessment and as	surance committee.	21530			
	by: Based on observati review, the facility for pharmacist identified antidepressant med contraindications for 2 of 5 residents a rationale for dupli was documented for	ent is not met as evidenced on, interview and document ailed to ensure the consultant of the need for reduction in dications or ensure or reduction were documented (R21, R7) and failed to ensure cate antidepressant therapy or 1 of 5 residents (R11) essary medications.	,	Corrected		
	(Celexa) and the ph lack of documentati contraindication of I R21's Resident Fac- indicated R21 had of	atidepressant medication narmacist failed to identify the ion for a reduction or reduction for the medication. See Sheet dated 12/7/16, diagnoses which included s, depressive episodes, and				
	10/16/16, indicated impairment. The MI of R21's mood includittle interest or pleastrouble falling or stamuch 2-6 days and energy 7-11 days of MDS also indicated behavioral symptom rejection of care on period. The MDS fi	num Data Set (MDS) dated R21 had severe cognitive DS indicated staff assessment uded the following symptoms: usure in doing things and aying asleep or sleeping too feeling tired or having little f the assessment period. The R21 exhibited no psychosis, ns, or wandering, but exhibited 1-3 days of the assessment uther indicated R21 received ntidepressant medications				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00470	B. WING		12/0	8/2016
	PROVIDER OR SUPPLIER EW HOSPITAL & NUF	RSING HOME 323 SOUT	DRESS, CITY, S TH MINNESO TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	daily. R21's Behavioral S Assessment (CAA) had Alzheimer's dis throughout the day behaviors included The physician opter antidepressant Cele helped greatly. R2 (quetiapine) since a R21's whereabouts assure safety and p others. The CAA a R21's Psychotropic 10/16/16, indicated due to the use of S son stated R21 was and irritable. R21 e hospitalization. Ser and had been helpf been decreased fro daily to 12.5 mg at R21's Physician Or 12/7/16, indicated F which included Cele morning for depres On 12/7/16, at 12:5 ambulate with assis from the dining roon negative resident b Review of Pharmac identified a pharma medication regimer pharmacist recomm	ymptoms Care Area dated 10/16/16, indicated R21 lease and wandered and night. Mood and other sundowning in the afternoons. If or the use of the exa (citalopram) which had had been on Seroquel admission, for hallucinations. needed to be monitored to prevent altercations with leso indicated R21 was "bossy". Medication Use CAA dated the care area was triggered eroquel (quetiapine). R21's as significantly more paranoid experienced delirium due to oquel was started on 10/30/15, rul. The Seroquel dose had are 25 milligrams (mg) twice bedtime. der Report dated 11/7/16 - R21 had medication orders exa (citalopram) 20 mg once a sive episodes. 7 p.m. R21 was observed to st of nursing assistant (NA)-Am to the common area. No	21530			

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00470		B. WING		12/	08/2016
	PROVIDER OR SUPPLIER EW HOSPITAL & NUF	RSING HOME	23 SOUT	DRESS, CITY, S H MINNESO ON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21530	Celexa for R21. The recommended doce effectiveness and s On 2/24/16, the phase appropriate behavious were compromising addressed and why interventions were recommendations recommendations recommendations recommendations resident revealed the recommendations reationale for continuous On 12/8/16, at 8:54 (DON) confirmed to antidepressant had contraindications to On 12/8/16, at 9:36 he would have expensive identified irregifor tapering of antidous on the confirmed it had no R7 received antidepand the pharmacist lacked documentatic contraindication of the confirmed it had no R7 received antidepand the pharmacist lacked documentatic contraindication of the confirmed it had no R7 received antidepand the pharmacist lacked documentatic contraindication of the confirmed it had no R7 received antidepand the pharmacist lacked documentatic contraindication of the confirmed it had no R7 received antidepand the pharmacist lacked documentatic contraindication of the confirmed it had no R7 received antidepand the pharmacist lacked documentatic contraindication of the confirmed it had no R7 received antidepand the pharmacist lacked documentatic contraindication of the confirmed it had no R7 received antidepand the pharmacist lacked documentatic contraindication of the confirmed it had no R7 received antidepand the pharmacist lacked documentatic contraindication of the confirmed it had no R7 received antidepand the pharmacist lacked documentation of the confirmed it had no R7 received antidepand the pharmacist lacked documentation of the confirmed it had no R7 received antidepand the pharmacist lacked documentation of the confirmed it had no R7 received antidepand the pharmacist lacked documentation of the confirmed it had no R7 received antidepand the pharmacist lacked documentation of the confirmed it had no R7 received antidepand the pharmacist lacked documentation of the confirmed the confirmed it had no R7 received antidepand the pharmacist lacked documentation of the confirmed the confirmed the lacked documentation of the	e pharmacist also umentation regarding ide effects of the medicarmacist recommended ors be identified, if behavious personal to the ability to care for Formon-pharmacological not enough be address regarding tapering of Coubsequent reviews of Formon-pharmacological not enough be address regarding tapering of Coubsequent reviews of Formon-pharmacological not be grading tapering Celevial to the physical authorized the physical authorized the pharmacist will be a summer to the pharmacist will be a summer	ed. No elexa R21's /16 to xa or cian. rsing or had ented. r stated ould need for R21. ed the d exapro) cord	21530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X3) DATE S A. BUILDING: COMPL			
		00470	B. WING		12/	08/2016
	PROVIDER OR SUPPLIER	SSING HOME 323 S	ET ADDRESS, CITY, S COUTH MINNESO OKSTON, MN 56	TA		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21530	had diagnoses which disease, dementia, disorder, mood disorder. The MDS cognitive impairment assessment of R7's symptoms: little intithings, trouble falling tired or having little assessment period exhibited no psychological betoward others, other directed at other	ch included Alzheimer's depression, psychotic order, dissociative and rs, and borderline personali indicated R7 had severe ant. The MDS indicated staff is mood included the following or staying asleep, feeling energy for 2-6 days of the and the MDS also indicated for behavioral symptoms not rejection of care or wander thavior symptoms directed any during the assessment urther indicated R7 receive antidepressant and	ng R7 ted ng,			
	indicated R7 trigger diagnosis of demer disturbance, explos hard of hearing. The behaviors were refucares, had no attent on exit doors. The mental health provimedication manages 12.5 mg in the morand 100 mg at bedimorning. R7's Psychotropic May 18/16, indicated Factor Lexapro and had a behavioral disturbathe medications see	mptoms CAA dated 9/18/16/red for behavioral problems attia with behavioral sive behavior, agitation and the CAA indicated R7's usal of cares, resistive with apts to elope, or pull or knot CAA also indicated R7 sawder for behavioral and ement and received Seroquening, 25 mg in the afternoois time and Lexapro 10 mg in Medication Use CAA dated R7 was on Seroquel and diagnosis of dementia with ances. The CAA also indicatemed effective without side of the red indicated the facility has a single problems.	ck r a lel n the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00470		B. WING		12/0	08/2016
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	RSING HOME		TH MINNESC TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE! ' MUST BE PRECEDE! SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21530	Continued From participating in a been trying to reduce and R7's behaviors indicated there had R7's Physician Ord 12/8/16, indicated Fincluded Lexapro 10 depressive disorded On 12/6/16, at 4:35 participating in a been gaged in the activate of the participating in a been gaged in the activate of the participating in a been gaged in the activate of the participating in a been gaged in the activate of the participating in a been gaged in the activate of the participating in a been gaged in the activate of the participating in a been gaged in the activate of the participating of a participating of participating of the participating of the participating of the participation of	ce the dose of R7 were monitored. been no change er Report dated 187 had medicatio 0 mg once a day with a start date p.m. R7 was observed as an bag toss activity, no behaviors a.m. R7 was observed as an activity of the problem List cist's Problem List cist reviewed R7 on 4/26/16, the problem to docume activity as a property of R7 on the problem are the problem of R7 on the problem are the problem of R7 on the problem of	The CAA 11/8/16 - n orders that for major of 9/8/09. served vity. R7 was s observed. served up nall with NA-A i. No It form is medication narmacist ent on eled to behaviors. ering of r's medication entation of ro. Infirmed not been to tapering	21530			
	would have identifie	ed irregularities re	elated to the				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00470	B. WING		12/08/2016		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
RIVERVI	EW HOSPITAL & NUF	RSING HOME	TH MINNESO TON, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE	
21530	Continued From pa	ge 34	21530				
	need for tapering of for R7.	f antidepressant medication					
	pharmacist stated some of the pharmacist stated some of the period of the pharmacist failed to rationale for the use	dication be identified and t been done. epressant medication Zoloft meron (mirtazipine) and the olidentify the record lacked e of duplicate therapy.					
	R11 had diagnoses disease, dementia, psychotic disorder a MDS indicated R11 impairment. The M of R11's mood inclufeeling tired or havi appetite or overeatialso indicated R11 annoyed 2-6 days of The MDS also indicated R11 annoyed symptoms had physical behavior symptoms had physical behavior assessment period R11 received antips antianxiety medicated.	•					
	indicated R11 exhibitions behavioral issues we control, confusion,	ymptoms CAA dated 8/22/16, bited numerous long standing hich included poor impulse talking and yelling, wandering, seexit seeking and demands to					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.				
		00470	B. WING		12/0	8/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
RIVERVI	EW HOSPITAL & NUF	RSING HOME	TH MINNESC TON, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
21530	Continued From pa	nge 35	21530				
	leave the facility. The refused to eat or confuther indicated R1	ne CAA indicated at times R11 ome out of his room. The CAA 1 was on psychotropic od and behaviors and did take					
	8/22/16, indicated F medications and ha hospital prior to adr indicated R11 had o anxiety, and Alzheir and conduct issues on lorazepam, Risp Seroquel as needed	Medication Use CAA dated R11 was on psychotropic ad a stay at a psychiatric mission to the facility. The CAA diagnoses of depression, mer's disease with behavior at The CAA indicated R11 was perdal, Remeron, Zoloft, and d and the facility would monitor ectiveness of the medications.					
	12/7/16, indicated F included Remeron bedtime for major of	der Report dated 11/7/16 - R11 had medication orders that (mirtazapine) 15 mg at depressive disorder and once a morning for major r.					
	wheeling himself in the common area. behaviors observed At 4:12 p.m. licens brought R11 his me short and abrupt. At 4:13 p.m. R11 he refused.	sed practical nurse (LPN)-A edications. R11's response was was invited to an activity and -A stated the resident had					
	identified a pharma medication regimer	cist's Problem List form cist had reviewed R11's n monthly since admission. narmacist indicated R11					

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00470	B. WING		12/0	8/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
RIVERVI	EW HOSPITAL & NUF	RSING HOME	TH MINNESC FON, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
21530	received Remeron and Risperdal for precommended door medications were had the pharmacist diduse of duplicative at the record lacked prationale for duplicationale for duplicationale for duplicationale for duplicate antidepres R11's record. On 12/8/16, at 9:36 there was no clinicate duplicate antidepres R11's record. On 12/8/16, at 9:36 the would have expensive identified irregulated antidepres duplicate	and sertraline for depression sychosis. The pharmacist umentation of how the delping with target behaviors. Not request a rationale for the ntidepressant therapy. Chysician documentation of ative antidepressant therapy. Cham. the DON confirmed at rationale for the use of ssant therapy documented in a sant therapy documented in a sant therapy documented in a sant therapy. Solution and physician for its had not done solutions are prescribed at a sant therapy and the consultant eview residents charts monthly ations are prescribed at a sant prescribed any sation and physicians are priately on medications. THOD OF CORRECTION: The or designee could review and /	21530				
l	or revise policies ar	or designee could review and / nd procedures related to Education could be provided					

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMP			SURVEY LETED
		00470	B. WING		12/0	8/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	RSING HOME	TH MINNESC TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	.D BE	(X5) COMPLETE DATE
21530	Continued From pa	ge 37	21530			
	to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan.					
	TIME PERIOD OF (21) Days.	CORRECTION: Twenty-one				
21535	MN Rule4658.1315 Drug Usage; Gener	Subp.1 ABCD Unnecessary	21535			1/2/17
	must be free from a unnecessary drug is A. in excessive therapy; B. for excessive C. without adec D. in the prese which indicate the codiscontinued. In addition to the discontinued. In addition to the discontinued in addition to the discontinued in addition to the discontinued. In addition to the discontinued in additional in addi	quate indications for its use; or nce of adverse consequences dose should be reduced or rug regimen review required in e nursing home must comply le Interpretive Guidelines for egulations, title 42, section Appendix P of the State, Guidance to Surveyors for acilities, published by the lth and Human Services, sing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan te Law Library. It is not				
	by: Based on observati	ent is not met as evidenced on, interview and document alled to ensure tapering of		Corrected		

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ED. '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00470	B. W	/ING		12/0	8/2016
	PROVIDER OR SUPPLIER	RSING HOME	TREET ADDRES 23 SOUTH MI ROOKSTON,	INNESO	ГА		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATIO		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21535	antidepressant med contraindications to for 2 of 5 residents a rationale for dupli was documented for reviewed for unnecestive	dications was attempted tapering were docume (R21, R7) and failed to cative antidepressant that 1 of 5 residents (R11) essary medications. Expressant medication (Or ed documentation of an antidication of tapering the Sheet dated 12/7/16, diagnoses which includes, depressive episodes.	Celexa) Celexa) and deted ive e of e. The mood erest or or ays and ys of icated ection iod.	535			
	Assessment (CAA) had Alzheimer's dis	ymptoms Care Area dated 10/16/16, indica ease and wandered and at night. Mood and					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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 REGULATORY OR LSC IDENTIFYING INFORMATION) RIVERVIEW HOSPITAL & REGULATORY OR LSC IDENTIFYING INFORMATION) A. BUILDING: B. WING COMPLETED A. BUILDING: B. WING PREFIX CROOKSTOR B. WING PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMPLETE DATE) COMPLETED COMPLETED A. BUILDING: B. WING PREFIX CROOKSTOR CROOKSTOR TAG COMPLETED A. BUILDING: B. WING PROVIDER'S PLAN OF CORRECTION COMPLETED COMPLETED TAG COMPLETED A. BUILDING: B. WING PROVIDER'S PLAN OF CORRECTION COMPLETED COMPLETED TAG COMPLETE TAG	_	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER RIVERVIEW HOSPITAL & NURSING HOME 323 SOUTH MINNESOTA CROOKSTON, MN 56716 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE 12700/2016 323 SOUTH MINNESOTA CROOKSTON, MN 56716 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE)				A. BUILDING.			
RIVERVIEW HOSPITAL & NURSING HOME 323 SOUTH MINNESOTA CROOKSTON, MN 56716 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 323 SOUTH MINNESOTA CROOKSTON, MN 56716 ID PREVIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE			00470	B. WING		12/0	8/2016
CROOKSTON, MN 56716 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROOKSTON, MN 56716 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE)	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	RIVERVI	EW HOSPITAL & NUF	RSING HOME				
	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
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 infected 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.	21535	behaviors included The physician had antidepressant Celhelped greatly. R21 (quetiapine) since a R21's whereabouts assure safety and pothers. The CAA al R21's Psychotropic 10/16/16, indicated due to the use of S son stated R21 was and irritable. R21 was and irritable. R21 was and irritable. R21 was and irritable. R21 was and irritable and been dec (mg) twice daily to R21's Physician Or 12/7/16, indicated I which included Celmorning for depres R21's undated Carantipsychotic medic dementia, delirium sundowning and re Celexa (started 1/3 be prescribed the lomedication. The Cadminister medicate monitor resident's medication, docum approaches tried, in management plan in non-pharmacologic redirect, folding clocoffee, food or snat	sundowning in the afternoons. chosen to help that with the exa (citalopram) which had I had been on Seroquel admission, for hallucinations. I needed to be monitored to prevent altercations with so indicated R21 was "bossy". If Medication Use CAA dated I the care area was triggered reroquel (quetiapine). R21's is significantly more paranoid experienced delirium due to roquel was started on been helpful. The Seroquel preased from 25 milligrams 12.5 mg at bedtime. If the Care area was triggered reroquel was started on been helpful. The Seroquel preased from 25 milligrams 12.5 mg at bedtime. If the Report dated 11/7/16 - R21 had medication orders exa (citalopram) 20 mg once a sive episodes. If the Plan identified R21 received precious the antidepressant solving while in the hospital, received the antidepressant solving with a goal R21 would precious the antidepressant solving with a goal R21 would precious the antidepressant solving and response to the tresident behavior and melement a behavior and melement a behavior and melement a penalogical approaches such as 1:1, thes, walk, movie, game,	21535			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		20470	B. WING			
		00470	B. WING		12/0	8/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUI	RSING HOME	TH MINNESC TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	Continued From pa	age 40	21535			
	to ambulate with as (NA)-A from the dir NA-A maintained a and provided cues lounge area. Intera	2:57 p.m. R21 was observed ssist of nursing assistant ning room to the common area. patient and calm approach for R21 to sit in a chair in the ction between NA-A and R21 negative resident behavior				
	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.					
	present revealed theOn 2/11/16, the period to be doing better in starting Celexa. We medication. I think Seroquel at night a well and I do want is months to work. Extrying to decreaseOn 3/11/16, the period to be the revenue of the control	nysician notes from 2/11/16, to ne following: hysician indicated R21 seems now with sundowning since e will continue her on that we should continue her on the s well since she is doing quite to give the Celexa a few rentually we could consider hysician indicated: R21 is ehaviors with Celexa and think we should continue these				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00470	B. WING		12/0	8/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	12/0	0,2010
RIVERVI	EW HOSPITAL & NUF	RSING HOME	H MINNESC TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
21535	currentlyOn 5/6/16, the phydecreasing her Sershe does with that a off it within a few mithe Celexa though a with her mood and at this point. No further recommedelexa or rationale by the physician. On 12/08/2016, at 8 nursing (DON) confantidepressant had contraindications to R7 received the anticlexapro) and the rof an attempt or comedication. R7's annual MDS dhad diagnoses which disease, dementia, disorder, mood disconversion disorded disorder. The MDS cognitive impairment assistance of 1-2 st living. The MDS inc R7's mood included interest or pleasure or staying asleep, for energy for 2-6 days The MDS also indice psychosis, verbal bothers, other behaviors.	ge 41 ysician indicated: We are oquel today. We will see how and maybe she can be totally onths. We will keep her on as it seems to be doing well behaviors are doing fairly well endations regarding tapering for continued use were made 3:54 a.m. the director of firmed tapering of R21's not been attempted nor had a tapering been documented. Attempted to the tapering been documentation intraindication of tapering the lated 9/18/16, indicated R7 ch included Alzheimer's depression, psychotic order, dissociative and res, and borderline personality indicated R7 had severe that and required extensive that for all activities of daily dicated staff assessment of the following symptoms: little in doing things, trouble falling elling tired or having little of the assessment period. Eated R7 exhibited no ehaviors directed toward from the symptoms not directed at care or wandering, but had	21535			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00470	B. WING		12/	08/2016
	PROVIDER OR SUPPLIER	SSING HOME 323 SOU	DRESS, CITY, S FH MINNESO TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21535	physical behavior sother 1-3 days durin MDS further indicated and antidepressant R7's Behavioral Sylindicated R7 trigger diagnosis of demer disturbance, exploshard of hearing. The behaviors were charefusal of cares, resattempts to elope, of the CAA also indic provider for behavior management and result the morning, 25 mg at bedtime and Lex R7's Psychotropic 9/18/16, indicated F Lexapro and had a behavioral disturbathe medications see effects. The CAA fubeen trying to reduce and R7's behaviors on every shift as not there had been not the morning or diagnoses of departs and a to diagnose of departs an	ymptoms directed toward ng the assessment period. The ed R7 received antipsychotic and medications daily. mptoms CAA dated 9/18/16, red for behavioral problems, atta with behavioral ive behavior, agitation and the CAA indicated R7's arted on every shift and R7 had sistive with cares, had no or pull or knock on exit doors. atted R7 saw a mental health				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00470		B. WING		12/	08/2016
	PROVIDER OR SUPPLIER	RSING HOME	323 SOUT	DRESS, CITY, S FH MINNESO TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21535	dose of the medical staff to administer staff to assess an drug treatment, mosedation, hypotens symptoms and moresponse to medical identified R7 had tabeing easily annoys swearing, history of nose causing nose object in mouth. The monitor R7's mouth psychiatry as needed protect other reside member to assist. Staff to implement interventions such when sitting in chair environment and all the more calm and please activity, no behavior on 12/7/16, at 7:16 and dressed and all and the use of a way ambulated to the color in a recliner. No be recommended to cobehaviors since decrease.	stion. The Care Plan Seroquel and Lexapred record the effective initor and report sign ion or anticholinergic initor resident behavior ation. The Care Plan arget behaviors of: hied, negative statement of physical aggression bleeds and putting in the Care Plan directed in provide appointment and get another The Care Plan also concern the Care Plan also concern pharmacological as providing a doll to rand maintaining a copproach to resident of p.m. R7 was observed and encouraged Fame. AA-B and R7 in asant. R7 was engagers observed. So a.m. R7 was observed and gait belt. Formmon area and was interested in the hall alker and gait belt. Formmon area and was interested in the same and was interested in the hall alker and gait belt. Formmon area and was interested in the same and was interested in the hall alker and gait belt.	o as eness of s of or and also story of nts, n, picks nedible d staff to nts with hysical, staff directed hold calm /ed Activity R7 to nteractions ned in the //ed up with NA-A R7 s seated rm nedication nacist on On	21535			

	(X3) DATE SURVEY COMPLETED	
00470 B. WING 12/08/	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 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (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 Zolott (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 personal hygiene and limited 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED		
		00470	B. WING		12/0	8/2016		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON SHOULD BE COMPLETE HE APPROPRIATE DATE			
21535	Continued From page 45		21535					
	indicated R11 exhibition behavioral issues we control, confusion, swearing, delusions leave the facility. Trefused to eat or coalso indicated R11 staff would see if the games on. The CA psychotropic medicand did take them we							
	8/22/16, indicated F medications and ha hospital prior to adr indicated R11 had o anxiety, and Alzheir and conduct issues on lorazepam, Risp Seroquel as needed	Medication Use CAA dated R11 was on psychotropic and a stay at a psychiatric mission to the facility. The CAA diagnoses of depression, mer's disease with behavior at The CAA indicated R11 was perdal, Remeron, Zoloft, and and the facility would monitor ectiveness of the medications.						
	12/7/16, indicated Fincluded Remeron bedtime for major of	der Report dated 11/7/16 - R11 had medication orders that (mirtazapine) 15 mg at depressive disorder and nce a morning for major r.						
	antipsychotic medic antidepressant med and antianxiety med R11 would be preso dose of medication to assess if R11's b	e plan indicated R11 received cation: risperidone, dications: Remeron and Zoloft dication: lorazepam with a goal cribed the lowest effective. The Care Plan directed staff behavioral symptoms or to the resident and/or others,						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00470	B. WING	·····	12/0	08/2016	
NAME OF PROVIDER OR SUPPLIER RIVERVIEW HOSPITAL & NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	SHOULD BE COMPLETE		
21535	intervene as neede management plan of and interventions, and response to ma adverse reactions. On 12/6/16, at 3:33 wheeling himself in the common area. wearing glasses. For a chair in the lou television. No behared the common and the common area wearing glasses. For a chair in the lou television. No behared the common and please short and abrupt. Loud noises other the did not like loud actorated a plant to attend a gander the common at time to attend a gander to the common and the common and the common and Review of Pharmace identified a pharmal medication regimer. On 11/23/16, the pharmacist did use of duplicate and the record lacked prationale for duplicate and the record lacked prational properties and the record lacked properties and t	d, implement a behavior with therapeutic approaches attempt non-pharmacological monitor R11's behavior, mood edication for effectiveness and p.m. R11 was observed dependently via wheelchair in R11 was well groomed and R11 transferred independently nge area and began watching					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
00470		B. WING		12/08/2016				
NAME OF	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	SHOULD BE COMPLETE			
21535	Continued From pa	ge 47	21535					
		onale for the use of duplicate rapy documented in R11's						
	11/2016, indicated effort to comply with related to the use of medications to include continued need, apprisk and/or benefits adequate indication psychotropic medicated plan of care along administration recondicated gradual devery 6 months for psychotropic medicated for	ation will be listed in residents' with MAR [medication rd]. The policy further ose reduction would be done those residents who received						
	The Director of Nur develop, review, an procedures to ensu- free from unnecess of Nursing or desig appropriate staff or The Director of Nur develop monitoring compliance.	THOD OF CORRECTION: sing or designee could id/or revise policies and are resident's medications are sary medications. The Director nee could educate all a the policies and procedures. sing or designee could systems to ensure ongoing						

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