#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5UEX PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00754 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 7 (L8) (L3) ADAMS HEALTH CARE CENTER (L1) 245509 1. Initial 2. Recertification (L4) 810 WEST MAIN STREET 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination (L6) 55909 015540300 (L2)(L5) ADAMS, 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 (1.9)05 HHA 13 PTIP 01 Hospital 09 ESRD 22 CLIA 6. DATE OF SURVEY 02 SNF/NF/Dual 06 PRTF 10 NF 08/20/2014 (L34)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 09/30 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 16 HOSPICE 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): Program Requirements 2. Technical Personnel 6. Scope of Services Limit To (b): Compliance Based On: 3. 24 Hour RN 7. Medical Director 12. Total Facility Beds 4. 7-Day RN (Rural SNF) (L18)\_1. Acceptable POC 8. Patient Room Size 49 5. Life Safety Code \_\_ 9. Beds/Room Not in Compliance with Program (L17) 13. Total Certified Beds (L12) Requirements and/or Applied Waivers: \* Code: A 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): (L15)49 (L37)(L38)(L39)(L42)(L43)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE 18. STATE SURVEY AGENCY APPROVAL Date: Josephine Hassinger, HFE NE II 10/16/2014 Kamala Fiske-Downing, Enforcement Specialist 10/16/2014 (L19)(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) RIGHTS ACT: Ownership/Control Interest Disclosure Stmt (HCFA-1513) X 1. Facility is Eligible to Participate 3. Both of the Above: \_\_\_\_ 2. 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 01/01/1988 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L25) (141)(L24)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal 07-Provider Status Change A. Suspension of Admissions: 00-Active (L44) (L27) B. Rescind Suspension Date: (L45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 03001 (L28) (1.31)31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

10/07/2014

(L32)



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245509

October 16, 2014

Ms. Georgette Hinkle, Administrator Adams Health Care Center 810 West Main Street Adams, Minnesota 55909

Dear Ms. Hinkle:

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 September 17, 2014 the above facility is certified for:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 skilled nursing facility beds located in rooms.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Division of Compliance Monitoring

Minnesota Department of Health

Telephone: (651) 201-4112 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

October 16, 2014

Ms. Georgette Hinkle, Administrator Adams Health Care Center 810 West Main Street Adams, Minnesota 55909

RE: Project Number S5509023

Dear Ms. Hinkle:

On September 9, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 20, 2014. 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 October 14, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 29, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 20, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 17, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 20, 2014, effective September 17, 2014 and therefore remedies outlined in our letter to you dated September 9, 2014, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program Division of Compliance Monitoring

Kumalu Fiske Downing

Minnesota Department of Health

Telephone: (651) 201-4112

Fax: (651) 215-9697

### Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

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

(Y1) Provider / Supplier / CLIA / Identification Number 245509	umber A. Building		IN BUILDING 01	(Y3) Date of Revisit 9/29/2014
Name of Facility			Street Address, City, State, Zip Code	
ADAMS HEALTH CARE CENTER			810 WEST MAIN STREET ADAMS MN 55909	

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

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
			Correction				Correction					Correction
ID Prefix			Completed <b>09/10/2014</b>	ID Prefix			09/17/2014		ID Prefix			Completed <b>09/11/2014</b>
Reg. #	NFPA 101				NFPA 101				Reg. #	NFPA 101		
LSC	K0011			LSC	K0038				LSC	K0046		_
			Correction				Correction					Correction
ID D (			Completed	10 D "			Completed		ID D "			Completed
ID Prefix	-		08/19/2014				08/15/2014					_
	NFPA 101			_	NFPA 101				Reg. #			
	K0062			LSC	K0147				LSC			
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix				ID Prefix			-		ID Prefix			_
Reg. #				Reg. #			=		Reg. #			_
LSC				LSC					LSC			
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix			•	ID Prefix					ID Prefix	-		_ `
Reg. #				Reg. #					Reg. #			
LSC				LSC					LSC			
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix			·	ID Prefix			-		ID Prefix			
Reg. #				Reg. #					Reg. #			
LSC				LSC					LSC			
Reviewed I	Зу	Reviewed	Ву	Date:	Signatu	ıre of Suı	veyor:				Date:	
State Agen	су	PS/KFD		10/16/20	14		25	822			(	09/29/2014
Reviewed I	Зу	Reviewed	Ву	Date:	Signatu	ire of Sui	veyor:				Date:	
CMS RO												
Followup t	o Survey Con	pleted on	1:							Summary of		
	8/13/2	2014			Uncorrec	cted Defic	ciencies (CM	IS-250	67) Sent to	the Facility?	YES	NO

### Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245509	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 10/14/2014
Name	e of Facility		Street Address, City, State, Zip Code	
ΑĽ	OAMS HEALTH CARE CENTER		810 WEST MAIN STREET ADAMS, MN 55909	

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

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item	(	(Y5)	Date
ID Prefix Reg. # LSC	F0156 483.10(b)(5)	- (10), 483.	Correction Completed 08/22/2014	ID Prefix Reg. # LSC	F0176 483.10(n)		Correction Completed 09/17/2014		ID Prefix Reg. # LSC	483.13(c)(1)(ii	i)-(iii), (c	Correction
ID Prefix Reg. # LSC	F0226 483.13(c)		Correction Completed 09/17/2014	ID Prefix Reg. # LSC	F0241 483.15(a)		Correction Completed 09/17/2014		ID Prefix Reg. # LSC	F0272 483.20(b)(1)		Correction Completed 09/17/2014
ID Prefix Reg. # LSC	F0276 483.20(c)		Correction Completed 09/17/2014	ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii)		Correction Completed 09/17/2014			F0312 483.25(a)(3)		Correction Completed 09/17/2014
	F0323 483.25(h)		Correction Completed 09/17/2014		F0332 483.25(m)(1)		Correction Completed 09/17/2014		Reg. #	F0431 483.60(b), (d)		Correction Completed 09/17/2014
ID Prefix Reg. # LSC	483.65		Correction Completed 09/17/2014	ID Prefix Reg. # LSC					_			
Reviewed E	Зу	Reviewed	Ву	Date:	Signature	of Sur	veyor:				Date:	
State Agen		KS/KFD		10/16/201			335	59				0/14/2014
Reviewed E	Зу	Reviewed	Ву	Date:	Signature	of Sur	veyor:				Date:	
Followup t	o Survey Co 8/20	mpleted or 0/2014	1:		Check for any Uncorrecte					Summary of 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: 5UEX Facility ID: 00754

1. MEDICARE/MEDICAID P	ROVIDER NO.	3. NAME AND AI (L3) <b>ADAMS HE</b>				4. TYPE OF ACTION: <u>2 (</u> L8)
(L1) <b>245509</b> 2.STATE VENDOR OR MED	ICAID NO	(L4) 810 WEST N	_	-		1. Initial 2. Recertification
(L2) <b>015540300</b>	ieriib ivo.	(L5) ADAMS, MI			(L6) <b>55909</b>	<ol> <li>Termination</li> <li>CHOW</li> <li>Validation</li> <li>Complaint</li> </ol>
5. EFFECTIVE DATE CHAN	GE OF OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEG	ORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY	<b>08/20/2014</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
8. ACCREDITATION STATU		03 SNF/NF/Distinct	07 X-Ray	11 ICF/III		FISCAL YEAR ENDING DATE: (L35)
	TJC 3 Other	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIF	ICATION	10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		A. In Complia	nce With		**	The Following Requirements:
To (b):			equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds	<b>49</b> (L18)		cceptable POC		4. 7-Day RN (Rural SN 5. Life Safety Code	
13.Total Certified Beds	<b>49</b> (L17)	X B. Not in Con Requirem	npliance with Prog ents and/or Appli			(L12)
14. LTC CERTIFIED BED BR	EAKDOWN				15. FACILITY MEETS	
18 SNF 18/1	9 SNF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
	49				•	
(L37) (I	L38) (L39)	(L42)	(L43)			
16. STATE SURVEY AGENC	Y REMARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION I	DATE):		
See Attached Remarks						
17. SURVEYOR SIGNATUR	Е	Date:			18. STATE SURVEY AGENCY	Y APPROVAL Date:
Marietta Lee, F	HFE NE II		09/18/2014	(L19)	Kamala Fiske-Downing	g, Enforcement Specialist 10/02/2014
	PART II - TO BE	COMPLETED I	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	STATE AGENCY
19. DETERMINATION OF E	LIGIBILITY		IPLIANCE WITH	H CIVIL		ancial Solvency (HCFA-2572)
1. Facility is Elig	gible to Participate	RIGI	HTS ACT:		3. Both of the Above	ol Interest Disclosure Stmt (HCFA-1513) e:
2. Facility is not	Eligible (L21)					<del></del>
	(221)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEM	MENT	26. TERMINATION ACTION	(L30)
OF PARTICIPATION	BEGINNING	B DATE	ENDING DAT	ГЕ	VOLUNTARY 00	<u>INVOLUNTARY</u>
01/01/1988					01-Merger, Closure 02-Dissatisfaction W/ Reimburs	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		03-Risk of Involuntary Termination	on
25. LTC EXTENSION DATE					04-Other Reason for Withdrawal	OTHER
	A. Suspension	n of Admissions:	(L44)			00-Active
(L	B. Rescind St	uspension Date:	(= ,			
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-15	39 32	. DETERMINATION	N OF APPROVAL	DATE		
	(L32)			(L33)	DETERMINATION APP	ROVAL
-						

#### 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

Facility ID: 00754

**C&T REMARKS - CMS 1539 FORM** 

CCN: 24-5509

STATE AGENCY REMARKS

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in the facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction

In addition, at the time of the August 20, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5509020 that was found to be unsubstantiated.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered September 9, 2014

Ms. Georgette Hinkle, Administrator Adams Health Care Center 810 West Main Street Adams, Minnesota 55909

RE: Project Number S5509023 and Complaint Number H5509020

Dear Ms. Hinkle:

On August 20, 2014, 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. In addition, at the time of the August 20, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5509020.

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. In addition, at the time of the August 20, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5509020 that was found to be unsubstantiated.

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;

Potential Consequences - 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:

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731

Fax: (507) 206-2711

#### 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 September 29, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 29, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (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 November 20, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 20, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process Minnesota Department of Health Division of Compliance Monitoring P.O. Box 64900

St. Paul, Minnesota 55164-0900

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

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division pat.sheehan@state.mn.us Telephone: (651) 201-7205

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health

Kumalu Fiske Downing

Minnesota Department of He Telephone: (651) 201-4112

Fax: (651) 215-9697

PRINTED: 10/02/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING  A. BUILDING			X3) DATE SURVEY COMPLETED			
		245509	B. WING			08/	20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET ADAMS, MN 55909		
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	тѕ	FC	000			
F 156 SS=D	as your allegation of Department's acceenrolled in ePOC, yat the bottom of the form. Your electror be used as verificated upon receipt of an on-site revisit of your validate that substate regulations has been your verification.  A recertification surcomplaint investigate completed at the time Complaint H55090 during this survey.  483.10(b)(5) - (10), RIGHTS, RULES, survey.  The facility must interest and in writing in a launderstands of his regulations governing responsibilities during facility must also protice (if any) of the survey. The facility must also protice (if any) of the survey amendments to writing.  The facility must interest and amendments to writing.	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.  acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with en attained in the standard survey.  20 was was not substantiated  483.10(b)(1) NOTICE OF SERVICES, CHARGES  form the resident both orally anguage that the resident or her rights and all rules and ing the stay in the facility. The rovide the resident with the entained in admission and during the entained in admission and during the entained in admission and during the entained in acceptable acknowledged in a form each resident who is a benefits, in writing, at the time	F 1	156			8/22/14
LABORATORY	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

Electronically Signed 09/18/2014

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

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F 156	resident becomes eitems and services facility services und which the resident other items and services and for which the resident the amount of charginform each resident the items and servi (i)(A) and (B) of this The facility must infat the time of admiss the resident's stay, facility and of chargincluding any chargunder Medicare or The facility must fullegal rights which in A description of the funds, under parage A description of the for establishing eligithe right to request 1924(c) which dete non-exempt resour institutionalization as spouse an equitable cannot be consider toward the cost of the medical care in his down to Medicaid each apposting of names.	nursing facility or, when the eligible for Medicaid of the that are included in nursing der the State plan and for may not be charged; those vices that the facility offers esident may be charged, and ges for those services; and not when changes are made to ces specified in paragraphs (5) is section.  Form each resident before, or esion, and periodically during of services available in the ges for those services, the for services not covered by the facility's per diem rate.  In this is a written description of includes:  In manner of protecting personal raph (c) of this section;  I requirements and procedures published in the extent of a couple's ces at the time of and attributes to the community e share of resources which ed available for payment the institutionalized spouse's or her process of spending	F 15	6				

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F 156	agency, the State li ombudsman progra advocacy network, unit; and a stateme complaint with the agency concerning misappropriation of facility, and non-codirectives requirem.  The facility must in name, specialty, ar physician responsible. The facility must provide information applicants for adminiformation about he Medicare and Medicare and Medicare and Medicare and Medicare and Medicare statements.	State survey and certification icensure office, the State am, the protection and and the Medicaid fraud control ent that the resident may file a State survey and certification resident abuse, neglect, and fresident property in the mpliance with the advance	F 1	56			
	by: Based on interview facility failed to ens reviewed for Medic whether or not to s review. Findings include: R16 was discharge due to achieved matherapy, according	NT is not met as evidenced v and document review, the cure 1 of 4 residents (R16) are denial letters had identified ubmit the bill to Medicare for ed from Medicare on 2/7/14, aximum potential in skilled to Skilled Nursing Facility on Continued Stay, issue		Please note that our signal either the response does not we agree with either the tag or the evidence presented to determination of non-comparespond and provide a writt correction because the law.  Per the Adams Health Care policy, Medicare denial letter mailed at least 2 days prior non-coverage effective date.	ot mean that gged deficiency to support any liance. We ten plan of requires it.  e Center's ers will be to the		

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F 156	dated of 2/4/14.  Document review of 2/4/14, which was some the two denial letter and Medicare A Denial achieved maximum R16's last day will be 2014. Please read enclosed Medicare selection on the baccopies where indicated them to Adams Hear envelope provided. The records. If you have me a call at the nurwas signed by hear Document review of Facility Determination and the facility Determination of Medicare on 2/4/14. The Medicare on 2/4/14. The Medicare on 2/4/14. The Medicare on Skilled Nursing Factor on Medicare Part the facility. Financial Skilled Nursing Factor on the facility of the facility of the facility of the facility. Financial Skilled Nursing Factor on the facility of the facility of the facility of the facility. Financial submit the bill to Medirector stated she letters.  Document review of Procedure policy under the facility of the facility of the facility of the facility of the facility. Financial submit the bill to Medirector stated she letters.	f the facility cover letter, dated sent to the family along with s, said, Enclosed you will find all letter for R16. R16 has a potential in skill therapy and see Thursday, February 6, the front and back of the denial letter and make your ck. Sign and date the colored ated on the forms and return alth Care Center in the Keep the white copy for your e any questions please give other listed above. The letter	F1	56	that the appropriate party is unava and a notation of attempts of all notification will be documented.  Policy reviewed by Finance Director DON, Administrator and HUC on 08/21/2014.  Random audits will be conducted or regularly basis by DON and/or her designee.  Results will be reviewed by QA/QI further recommendation.	or, on a	

-	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION (X	(3) DATE SURVEY COMPLETED
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F 176 SS=D	unavailable the lette least two days prior date. A notation of documented."  483.10(n) RESIDER DRUGS IF DEEME An individual reside the interdisciplinary §483.20(d)(2)(ii), ha practice is safe.  This REQUIREMENT By: Based on observative review, the facility for (R5) was assessed nebulizer treatment Findings include:  On 8/14/14 at 7:09 room sitting in her was a staff were present. The machine was runedication left in the According to the phomography of 5 on 5/25 cognitive impairment had a diagnosis of disease, oxygen designed to the physician's ord R5 was to receive in the physician's ord R5 was to receive in the machine was to receive in the physician's ord R5 was to receive in the ph	er of denial will be mailed at to the non-coverage effective attempts of notification will be NT SELF-ADMINISTER ED SAFE ent may self-administer drugs if team, as defined by as determined that this  NT is not met as evidenced tion, interview and document ailed to ensure 1 of 1 resident to be safe to self-administer a transfer of the safe transfer of the safe to self-administer a transfer of the safe trans	F 156		y staff fee be ation  14 on feek 3 fee.

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

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F 176	Administration of Dibeen informed of he drugs and she chost the facility.  During an interview nurse (LPN)-C as sistated that R5 was removed it from C5 the resident had just woke and stated, "LPN-C] forgot about there was no order nebulizer. LPN-C something else and away.  During an interview director of nursing (no assessment to sith that she had spoke had told her that she work with another reback.  The policy titled Sel dated 3/28/13 reads admissions person he/she wishes to se resident has the rig the facility. If the resident she chost section in the site of the section of the sec	ed 2/18/14 titled Self rugs, documents that R5 had er right to self-administer se to defer the responsibility to on 8/14/14 licensed practical he checked on R5. LPN-C done with the nebulizer and 's face. LPN-C stated that st started the nebulizer. R5 I think you [reference to t me." LPN-C confirmed that for R5 to self-administer the tated she had to go do I didn't get back to R5 right  on 8/14/14 at 12:30 p.m., the DON) confirmed that R5 had self-administer the nebulizer, in to LPN-C and that LPN-C e had left the resident alone to esident real quick and come  of Administration of Medication, so On admission, the asks the resident whether elf-administer drugs. The hit to defer the responsibility to seident expresses the desire to	F 1	76		
F 225	will be completed by		F 2	25		9/17/14

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F 225 SS=E	been found guilty or mistreating residen had a finding entered registry concerning of residents or mist and report any know court of law against indicate unfitness for other facility staff to or licensing authority. The facility must entered involving mistreatm including injuries of misappropriation of immediately to the stoother officials in a through established State survey and control of the facility must have a state of all into the administrator representative and with State law (includent, and if the state of the	PORT DIVIDUALS  It employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a tan employee, which would or service as a nurse aide or the State nurse aide registry ties.  Issure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law diprocedures (including to the ertification agency).  Inve evidence that all alleged ughly investigated, and must ential abuse while the rogress.	F 225				

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F 225	by: Based on interview facility failed to imma abuse to the designesidents (R18) revialled to immediate neglect to the designesidents (R68) reviand failed to ensure R1, R6, R12, R20, or actual abuse and comprehensively in measures put into put the residents involved lack of monitoring some action of the facility as they are remained in the facility as they are remained in the dignity charged to our care made immediately. The control of the CEP [COHFC of the control of the CEP of the control of the control of the CEP of the control of th	NT is not met as evidenced and document review, the rediately report an allegation of nated state agency for 1 of 9 viewed for abuse and neglect; by report an allegation of nated state agency for 1 of 9 iewed for abuse and neglect; a 7 of 9 residents (R18, R68, R25) reviewed for allegations of neglect incidents were evestigated and immediate place to provide protection to red or potentially at risk due to staff who committed the abuse.	F 22	Per Adams Health Care Center allegations of abuse and negler reported immediately to the destate agency. A comprehensive investigation will be conducted staff involved will be monitored compliance to prevent reoccurr.  All staff reeducated on 09/17/20 regarding Abuse Protection Procesident allegation of abuse, invand protection and reporting.  Audits will be conducted once process for a month and once per montmonths. Social Services Direct Administrator and/or their design responsible to monitor for complex Results will be forwarded to QAC Committee for review and for for recommendation.	et will be signated and the for ence.  214 stocol, restigation oer week h for 3 or, DON, gnee will be bliance.	

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F 225	roommates, family may service as with information leading. The facility will profit the investigative promade to maintain the rights, liberties and and after the investigative promade to maintain the rights, liberties and and after the investigative promade to maintain the resident will be free the suspected staff rescheduling or relimember, and by momember during his Definitions Related Abuse- Is conduct that procedures or or emotional distree This includes; willful unreasonable configures punishment with remetal anguish or definition of STAFF RESIDENTS:  During telephone in a.m., licensed sociaudits of staff treat included in care concouncil minutes, if LSW-A stated the aquestion- are there cares?" LSW-A vedocumentation of a residents. LSW-A resident rights Januattend, then had to	I chart, care plan and interview members, and visitors who nesses to the incident, or give up to the incident. Protection: tect residents from harm during ocess. All attempts will be he resident's safety, dignity, sense of well-being during tigation of the incident The effom possible retaliation by members by means of ocating the suspected staff onitoring the suspected staff on the facility  I To The Abuse Protocol  (not accidental or therapeutic) could produce intentional pain as for the VA [vulnerable adult]. It infliction of injury, inement, intimidation or usuality physical harm, pain,	F 2:	25		

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F 225	1/2014 to 8/2014, r regarding staff trea review of care conf 8/20/14, revealed n staff treatments or  The facility lacked of staff care and treatments or  STAFF VULNERABE  Document review orights and vulnerabe 1-8-14, revealed all reports received trastaff hired 3/14/14, 3/14/14.  ADMINISTRATOR	lents.  If resident council notes from evealed no questions tment or cares. Document erence notes 1/1/14 to o questions or notes regarding cares.  Idocumented evidence of audits	F 22	25		
	During an interview administrator stated be completed with part of vulnerable a administrator stated resident interviews part of the investigate service office. The director of nursing, administrator compresident cares and	OR NEGLECT INCIDENT:  on 8/20/14 at 2:33 p.m., the d she expected interviews to other residents and staff as idult investigation. The d she expected staff and to documented and kept as ation and filed in the social administrator stated the licensed social worker, and eleted audits to monitor interactions when there was a with a specific staff member.				

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F 225	documentation to s had been complete	erified there was no how the monitoring or audits d.	F 2	25			
	7/10/14 revealed R and Depression. R impairment with cle extensive assistant limited assist of one supervision with on locomotion. The caindicated R18 was, person and place time and dates. Is a	imum Data Set (MDS) dated 18 had diagnoses of Dementia 18 had severe cognitive ar speech. R32 required be with one staff with dressing, a staff for bed mobility, and a staff for transfers and are plan dated 7/23/14  " alert and orientated to has some confusion with able to communicate needs. Is a decisions independently."					
	family (F)-B members sometime in July 20 concern to her regard the television not with the facility went hor returned to the facility went to was a piece of black control. FM-B state concern and removatelevision. FM-B state television and sidiscussed at the cathis year. FM-B state stated the incident of the sometime	on 8/12/14, at 11:03 a.m. er stated she was at the facility 014 when R18 voiced a arding the remote control for orking. FM-B stated she left me and got new batteries, ity, placed new batteries in the note still did not work. FM-B ook at the controls and there k Velcro tape over the volume d she alerted staff to this red the tape from the ated the concerns related to taff approach with R18 were re conference held in July of the facility staff apologized and with R43 's television should. FM-B also stated at care					

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F 225	was discussed, sta some of their staff rough around the ethis as staff not was was told the facility approach on how to The care conference 7/25/14 progress nasked about the incadhesive being pla Resident's TV. [F-Eafternoon and askelow. Resident repoly work, so [F-B] left t [F-B] returned and states it still did not the TV to find a voltime [F-B] found the caught off guard by nurse. Social Servi incident had alread of the Administrato and the staff responsal the staff responsal to the TV to find a voltime are problems volume. I was because I had spendence. 'Social Sethis kind of behavior it is considered res	age 11 concerns with staff approach ted was told by the facility have an approach that is "adges" and he may perceive nting to help him. Stated she was working on staff to speak to residents.  The progress noted dated on the volume receptor on the volume receptor on the date of the volume receptor on the date of the volume was so the volume was a thin the volume was and took the volume to a ces informed the [F-B] that this by been brought to the attention or, DON, and Social Services ansible for doing this had been then stated, "Well I know with getting [R43] to keep his a frustrated when I found it not so much time trying to fix the ervices assured the [F-B] that or from staff is not allowed and ident manipulation. Assured ing monitored so it does not	F 22	5		
	LSW-A verified place volume control of F	on 8/20/14 at 9:40 a.m., the cing Velcro black tape over the R43's television would be hment that resulted in				

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F 225	R43's room and wo maltreatment/abuse LSW-A verified a verified to the design a report should have asked what measu provide protection to the facility, LSW-A monitoring the staff identified in the incifacility was monitor LSW-A verified mondone. LSW-A verified mondone. LSW-A verified there was reported to the investigation verified there was reported to another volume control of Roccurred to another volume administrator stated adult report had be and stated, "Yes, the over the volume convolume convolum	s ability to use the television in old be considered	F 22	,		
	and verified the fac abuse prohibition p	eport should have been made ility did not follow their facility rotocol which included the led abuse in this case to the gency.				

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F 225	administrator stated comprehensive into other residents and adult investigation. expected the staff a documented and ke investigation and fill The administrator is (DON), LSW-A and ongoing audits to minteractions when the with a specific staff verified there was resident interactions.	on 8/20/14 at 2:33 p.m., the d she expected erviews to be completed with staff as a part of a vulnerable. The administrator stated she and resident interviews to be	F 22	5		
	and PROTECTION R68 had diagnosis accident and aphas review of the admis (MDS) an assessm review of the same extensive assist of daily living, extensit transfers and toileti memory problem a decision making.  Document review of dated 7/15/14, directly related to cerebrove weakness, requirect transfers and ambubalance. The care	that included cerebrovascular sia according to document sion Minimum Data Set ent dated 7/2/14. Document MDS identified R68 required one to two staff for activities of the assist of two staff for ng, had short and long term and moderately impaired  If the facility resident care plan cted R68 had impaired mobility ascular accident, generalized a physical assistance with allation, unsteady gait and plan directed physical assist sfers and had history of self-				

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	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909	,	
(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)	_D BE	(X5) COMPLETION DATE
F 225	submitted to the de of Health Facility Colidentified the follow 7/9/14. Maltreatmer required assist of oliving and transfers transferring self. Maintenance felt the floor, reported the responded "I don't Maintenance felt the nurse neglected to was notified of the floor nursing on 7/10/maintenance staff, nursing assistant. On the OHFC report nursing was notified and "Did not see nurse states she was resident." Review of hand written noted the director of nursing 8:15 a.m. and state Social Services bed discrepancy. The floor the floor for R68 was delivery person, the	If facility investigation report signated state agency (Office complaints) dated 7/10/14, ing: Date of incident was ent identified was neglect. R68 ne staff for activities of daily, although R68 had history of aintenance staff found R68 on to licensed wing nurse who is thave time for that. "Heremark was rude and felt the respond immediately. LSW-A7/9/14 incident by the director 14. LSW-A interviewed nurse involved, and one Review of a hand written note at fax sheet revealed director of the don 7/9/14 by maintenance as in the room at 8:30 a.m., any discrepancy, because as in the room at 8:05 to help of director of nursing interview ated 7/10/14, at 11:45 a.m., for of nursing received a subout the fall at 10:00 a.m. stated the message was at add, "I did not report this to cause there was no all occurred at 8:05 am [a.m.] corted it to me by 8:15."  The estaff indicated the fall is witnessed by the oxygen ere was no documented axygen delivery person was	F 22	5		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G	` '	E SURVEY MPLETED
		245509	B. WING		08	/20/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	Report dated 7/9/1 7/9/14 at 8:05 a.m. the floor. R68 was medical treatment  Document review of dated 7/15/14, ider discussed therapy, pleased with care in o questions or coresident.  Although the incide a.m., the facility did incident of suspect state agency until 5.  During telephone in a.m., LSW-A state incident on 7/10/14 the nurse to responshe interviewed the and maintenance is reported that she had maintenance is reported that she had maintenance is interviewed. LSW-potential neglect with facility or to the daministrator state incident of potential day.  The facility had no	of facility Resident Incident/Fall 4, revealed fall occurred on 1, when janitor reported man on a unable to speak and no needed.  of facility care conference note natified R68 and family plans to return home, stated resident received. There were mments on staff treatment of the designated of the lead neglect to the designated of the lead neglect to the designated of the lead nation of the lead to lock up medications and R68 on the floor. LSW-A stated had to lock up medications and R68 on the floor. LSW-A aff or residents were and the land of the lead of the lead of the lead of the lead to lock up medications and R68 on the floor. LSW-A aff or residents were and land land land land land land land	F 22	5		
	The facility had no of a comprehensiv					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY IPLETED
		245509	B. WING			08/	20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		81	TREET ADDRESS, CITY, STATE, ZIP CODE  10 WEST MAIN STREET  DAMS, MN 55909	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 225	and the facility lack LN-A for compliance of an incident like the was no documental protection of R68 deallegation of neglect R1 had diagnosis the dementia according admission Minimum assessment dated the same MDS identification and transfer to be compairment and receivated to like the same MDS identification and transfer to be compairment	ed evidence of monitoring e and to prevent reoccurrence ne one with R68. Also there tion provided in regards to the uring the investigation of the ct.  nat included heart failure and g to document review of R1's n Data Set (MDS), an 7/24/14. Document review of ntified R1 had severe cognitive juired the assistance of one idaily living which included		225			
	submitted to the Of Complaints dated 7 Date of incident wa identified was mistr of one for activities and was a high fall report stated on 7/1 R1 state wanted to nursing assistant (N responded to R1 by after lunch." Accoreported the incider identified director o worker (LSW)-A tal	f facility investigation report fice of Health Facility 7/18/14, identified the following: s 7/18/14, Maltreatment eatment. R1 required assist of daily living and transfers, risk due to unsteady gait. The 8/14, activity aid overheard lay down. Activity aid notified NA)-Z on that wing who a saying "can't lay down until rding to the report, activity aid not to supervisor. The report of nursing and licensed social ked with NA-Z. NA-Z received or failure to respond to the					

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245509	B. WING		08	/20/2014		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 810 WEST MAIN STREET ADAMS, MN 55909	<u> </u>	•		
(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 C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 225	request of R1, and already received a report stated LSW of the facility to deconcerns or complete Although the investigation and a interviews.  Document review report dated 8/11/1 to go back to bed. During telephone in a.m., licensed soci was aware of the facility, LSW-A warning, was educed was moved to ano stated she had interview other nursing a shift. LSW-A state investigation and stee incident report. Although the investigation, no or interviewed regard facility lacked evidence.	it was learned that NA-Z had verbal warning that week. The A would visit with "residents termine if there are any aints relating to" staff member. tigation report included a hand A-Z, there was no further nce of a comprehensive my further staff or resident of facility care conference 4, identified R1 "often requests	F 2	225				

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SURPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED
		245509	B. WING _		08/20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP COD 810 WEST MAIN STREET ADAMS, MN 55909	
(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 SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLÉTIC
F 225	Continued From pa the incident.		F 22	25	
	and arthritis accord R6's admission Mir assessment dated the same MDS ider	nat included diabetes mellitus ing to document review of himum Data Set (MDS), an 7/17/14. Document review of hified R6 had severe cognitive puired the assistance of two d transfers.			
	dated 7/29/14, direct mobility related to go staff to assist R6 to bathroom with when assist, required phybed mobility, transfer	of facility resident care plan cted staff R6 had impaired generalized weakness, directed ambulate to and from the eled walker and stand by visical assistance of one for ers, ambulation, and ion, and received physical gening.			
	Office of Health Far 7/16/14, identified the was 7/16/14; Maltre mistreatment and none for activities of was independent where the coordinator (HUC) are quested to use be nursing assistant. It room later, R6 was been assisted to be (NA-Y) came to R6 and R6 could go in to the bathroom and social services and	vestigation report submitted to cility Complaints dated he following: Date of incident eatment identified was leglect. R6 required assist of daily living and transfers, and ith wheelchair mobility. The 7/16/14, health unit entered R6's room, R6 athroom, and HUC notified a When HUC returned to R6's in bed. R6 stated had not athroom, that nursing assistant and said she was too busy, her pants. HUC assisted R6 d then reported the incident to administrator. The included hand written			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245509	B. WING			08/2	20/2014	
NAME OF PROVIDER OR SUPPLIER  ADAMS HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, 810 WEST MAIN STREET ADAMS, MN 55909	ZIP CODE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG				(X5) COMPLETION DATE	
F 225	investigation report interview with the N was no further door comprehensive invor resident interview. Document review or report dated 7/29/1 of one for activities was occasionally in own toileting needs unsteady gait and f During telephone in a.m., licensed socia was aware of the 7 investigated the incone other nursing a measures were put protection to R6 an LSW-A stated NA-LSW-A stated document at a staff interviews report. LSW-A veriwere interviewed rewitten interview with ad no further document of the facility lack NA-Y to prevent removed to another uresidents.	C and NA-Y. Although the included a hand written IA-Y and HUC involved, there umented evidence of a estigation and any other staff	F 2	225				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		245509	B. WING _		08/	/20/2014	
NAME OF PROVIDER OR SUPPLIER  ADAMS HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 225	5/12/14. Document identified R12 requivataff for activities of toileting and had seen because of toileting and had not been to the formal to the incident was supposed to be toil did required as the incident details 7/21/14, revealed of and had not been to the toileting and to the toileting and to be toileting to the toileting and to be toileting and to be toileting and to be toileting and to the toileting and to be toileting and to be toileting and to the to	(MDS) an assessment dated to review of the same MDS ired extensive assist of two found daily living, transfers and evere cognitive impairment.  If the facility resident care planted R12 had impaired lated to weakness, gait gal blindness and required extensive assistion, and even hours. The care planted R12 was alert and had short and long term at The care plan dated R12 had alteration in only incontinent of bowel and extensive assist of two to found the toilet with mechanical lift.  If facility investigation report of Health Facility Complaints /14, identified the following: s 7/21/14, Maltreatment ext. R12 was legally blind, and one staff person for all ing, required assist of one to ears, and at times is transferred. On 7/21/14, at 6:25 a.m., the floor by bed, blood on the bow hematoma. Director of strator determined R12's care followed. Document review of submitted to OHFC dated ares had not been completed oileted within the last four was not followed as R12 was eted every two hours and night omplete R12's cares and get	F 22	5			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245509	B. WING _		08	3/20/2014		
NAME OF PROVIDER OR SUPPLIER  ADAMS HEALTH CARE CENTER			•	STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 225	morning hours and out of bed.  Document review of incident/fall report of found on floor, fall if hematoma opened.  Document review of investigation works 7/21/14, revealed Regoing on, was last of activities or behavioral	At 2 is restless in the early had a history of trying to get of the facility resident dated 7/21/14 revealed R12 from bed, and old elbow of the facility post fall huddle heet with date of fall of at 2 did not know what was observed in bed, no unusual ors, was last toileted at 2:40 occumplaints, no environmental of facility care conference 4, identified R12 was and bladder and staff to	F 22	25				
	of a comprehensive or resident interview	e investigation, no other staff wed regarding the staff person, ed evidence of monitoring						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245509	B. WING			08/	20/2014	
NAME OF PROVIDER OR SUPPLIER  ADAMS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  810 WEST MAIN STREET  ADAMS, MN 55909					
(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 SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 225	NA-X to determine resident needs/trea reoccurrence of needs according to docum Minimum Data Set 7/17/14. Documen identified R20 requitive staff for activitie assist of one staff for had moderate cognitive detection of the staff for activities assist of one staff for had moderate cognitive detection of the staff for activities assist of one staff for had moderate cognitive detection one assist, and one out of bed.  Document review of submitted to the Off Complaints dated 8 Date of incident was identified was verbative staff assist for the staff assis	compliance in meeting tments to prevent glect.  that included diabetes mellitus nent review of the annual (MDS) an assessment dated treview of the same MDS ared extensive assist of one to es of daily living, extensive or transfers and toileting, and exitive impairment.  If the facility resident care plan acted R20 had impaired ight sided weakness, required with mobility, transfer with assist getting resident in and a sitive impairment.  If facility investigation report fice of Health Facility (A6/13, identified the following: 8 8/2/13. Maltreatment all abuse. R20 required one to transfers. R20 reported to the reno 8/6/13, that a nursing and been verbally rude and an R20 asked for help to stand or of nursing and administrator LSW-A interviewed other on the care list for the NA-W complaints. Nursing assistant transfered by LSW-A, director	F 2	25				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245509	B. WING			08/2	20/2014	
NAME OF PROVIDER OR SUPPLIER  ADAMS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  810 WEST MAIN STREET  ADAMS, MN 55909					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIZ TAG		SHOULD BE		(X5) COMPLETION DATE	
F 225	a.m., LSW-A stated incident. LSW-A st speak respectfully to the facility had not of a comprehensive interviewed regarding facility lacked evided determine compliar does not reoccur with R25's admission Minglar for bed mobility assistance of one for personal hygiene. Indicated R25 was and place. Confusishort term memory simple decisions in guidance from family decisions."  During an interview reported that a nurs room to answer his asked the nursing a light off because it is nursing assistant to light on to see to wo nursing assistant he light on until they tu to R25 the nursing a that if he continued	terview on 8/20/14 at 9:40 I she did not remember the ated she expected staff to o residents.  Further documented evidence investigation, no other staffing the staff person, and the nce of monitoring the NA-W to nce and that verbal abuse with NA-W.  Inimum Data Set (MDS) dated 25 had a brief interview for S) of 5, which indicated severe unired extensive assistance of and toileting, and extensive or dressing, eating, and The care plan dated 7/24/14 I alert and oriented to person on with time/dates and some impairments. Able to make dependently. Requires ly and staff with healthcare  on 8/11/14 at 4:25 p.m. R25 sing assistant came into his light about 4:00 a.m. and R25 assistant to turn the hallway was keeping him up. The lid him they had to keep the ork. R25 stated he told the ewould keep putting his call rined the light off. According assistant replied back to him to put his call light on that it f an in not a nice tone. R25	F 2	225				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245509	B. WING		08/	20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER	8	STREET ADDRESS, CITY, STATE, ZIP CODE B10 WEST MAIN STREET ADAMS, MN 55909		
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	worker (LSW)-A 8/2 stated she was not On 8/13/14 at 11:00 R25 and LSW-A, R nursing assistant w would get pissed of keep putting his cal During an interview 9:20 a.m., LSW-A vinterview other staff as part of the inves allegation of verbal LSW-A did not indic documentation they measures that had	with the licensed social 12/14 at 3:30 p.m., the LSW-A aware of this incident. 20 a.m. during an interview with 25 stated that it was a female ith a pony tail that told him she f when he stated he would I light on.  with the LSW-A on 8/20/14 at rerified that she did not frembers or other residents tigation process when this abuse was told to her. Eate or have any or provided any protective been put into place to prevent a incident for R25 or any other	F 225			9/17/14
SS=E	policies and proced mistreatment, negle and misappropriation.  This REQUIREMENT by: Based on interview facility failed to follor Protocol to immedia abuse to the designesidents (R18) revito immediately report the designated statement in the statement of the sta	velop and implement written		The staff of Adams Health Care C will follow the Abuse Prohibition Proto immediately report any allegation abuse and neglect to the designate agency, will conduct a comprehens investigation and will provide protect the residents involved.	otocol n of ed state sive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245509	B. WING			08/2	20/2014
	PROVIDER OR SUPPLIER  HEALTH CARE CENT	ER		81	REET ADDRESS, CITY, STATE, ZIP CODE O WEST MAIN STREET DAMS, MN 55909		
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	to ensure 7 of 9 res R12, R20, R25) rev incidents were comhad measures put i protection.  This had the potent the facility.  Findings include:  ABUSE PROHIBIT Document review o Protocol, updated 7 Care Center's miss safe and secure livimaintain the dignity charged to our care made immediately. made to the CEP [c OHFC [office of heatimediately Investigated by faci addition the Social resident(s) medical roommates, family may service as witr information leading The facility will prote the investigative promade to maintain the rights, liberties and and after the invest resident will be free the suspected staff	idents (R18, R68, R1, R6, iewed for abuse and neglect prehensively investigated and nto place to provide  ial to affect all 45 residents in	F 2	26	The facility policy was reviewed at a Staff meeting on 09/17/2014.  Audits will conducted once per week month and once per month for 3 m to monitor for compliance. Social S Director, DON, Administrator and/odesignee are responsible to monitor compliance.  Results will be forwarded to QA/QI Committee for review and further recommendation.	ek for a onths services or their	

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(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 ADEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 226	member, and by member during his/Definitions Related Abuse- Is conduct (that procedures or or emotional distress This includes; willfu unreasonable confingunishment with resemble anguish or definition of the AUDITS OF STAFF RESIDENTS:  During telephone in a.m., licensed social audits of staff treatr included in care corcouncil minutes, if the LSW-A stated the adjunction- are there cares?" LSW-A verification of a residents. LSW-A stated she are sidents. LSW-A stated she are sident rights Januattend, then had to LSW-A stated she are spectfully to resident review of care confinitions. The sident review of care confinitions are staff treatments or of the staff trea	conitoring the suspected staff ther presence in the facility To The Abuse Protocol Inot accidental or therapeutic) could produce intentional pain as for the VA [vulnerable adult]. I infliction of injury, nement, intimidation or sulting physical harm, pain, eprivation."  TREATMENT OF  Sterview on 8/20/14, at 9:40 al worker (LSW)-A stated ment of residents were inference notes and in resident there were any concerns. It was to ask a "general any concerns with staff or rified there was no other udits for staff treatment of stated staff were educated on lary 2014. If they did not make up the in-service. Expected staff to speak ents.  If resident council notes from evealed no questions ament or cares. Document erence notes 1/1/14 to on questions or notes regarding cares.  Idocumented evidence of audits	F 2	226			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SURPLIER/CLIA

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECT ORRECTIVE ACTION SHOU FERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 226	Document review orights and vulnerab 1-8-14, revealed all reports received trastaff hired 3/14/14, 3/14/14.  ADMINISTRATOR COMPREHENSIVE ALLEGED ABUSE  During an interview administrator stated be completed with opart of vulnerable a administrator stated resident interviews part of the investigate service office. The director of nursing, administrator compresident cares and concern identified with administrator view.	ge 27  BLE ADULT TRAINING:  If staff training on resident le adult training conducted on staff identified in incident ining with the exception of one who received the training on  EXPECTATIONS for a EINVESTIGATION OF AN OR NEGLECT INCIDENT:  on 8/20/14 at 2:33 p.m., the dishe expected interviews to other residents and staff as dult investigation. The dishe expected staff and to documented and kept as ation and filed in the social administrator stated the licensed social worker, and leted audits to monitor interactions when there was a with a specific staff member. Perified there was no how the monitoring or audits	F 2	26	DETIGIENCY			
	R18's quarterly Min 7/10/14 revealed R and Depression. R							

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	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CO 810 WEST MAIN STREET ADAMS, MN 55909	<b>.</b>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 226	extensive assistand limited assist of one supervision with on locomotion. The caindicated R18 was, person and place time and dates. Is a able to make simple During an interview family (F)-B members sometime in July 20 concern to her regathetelevision not with the facility went hor returned to the facility went hor returned to the facility went to was a piece of black control. FM-B state concern and remove television. FM-B state concern and remove television. FM-B state the incident not have happened conference when c	ge 28 ce with one staff with dressing, e staff for bed mobility, and e staff for transfers and re plan dated 7/23/14   " alert and orientated to . has some confusion with able to communicate needs. Is e decisions independently. "   on 8/12/14, at 11:03 a.m. er stated she was at the facility 014 when R18 voiced a arding the remote control for orking. FM-B stated she left me and got new batteries, lity, placed new batteries in the note still did not work. FM-B look at the controls and there k Velcro tape over the volume d she alerted staff to this red the tape from the ated the concerns related to taff approach with R18 were are conference held in July of ted facility staff apologized and with R43 's television should. FM-B also stated at care oncerns with staff approach ted was told by the facility have an approach that is " dges " and he may perceive oncerns with staff approach that is " dges " and he may perceive thing to help him. Stated she was working on staff of speak to residents.  The progress noted dated once the progress noted dated on the volume receptor on ced on the volume receptor on the volume receptor on the volume receptor on the plant of the plant of the progress noted dated on the volume receptor on the	F 2	226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		245509	B. WING _		08/	/20/2014	
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909			
(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) COMPLETION DATE	
F 226	Resident's TV. [F-E afternoon and askelow. Resident repowork, so [F-B] left to [F-B] returned and states it still did not the TV to find a voltime [F-B] found the caught off guard by nurse. Social Servincident had alread of the Administrato and the staff respotalked to. The [F-B] there are problems volume down. I was because I had speremote. 'Social Sethis kind of behavior it is considered rese [F-B] that this is be happen again "  During an interview LSW-A verified plan volume control of F considered a punis deprivation in R43's R43's room and wormaltreatment/abus LSW-A verified a verified a verified plan volume to the design a report should have asked what measure provide protection the facility, LSW-A monitoring the staff	B] came to visit resident one ed why his TV volume was so red that the remote didn't' o go get batteries from home. placed them in the remote and work. [F-B] then went up to ume control button, at which e Velcro. [F-B] states [F-B] was this and took the Velcro to a ces informed the [F-B] that this by been brought to the attention r, DON, and Social Services ensible for doing this had been then stated, "Well I know with getting [R43] to keep his frustrated when I found it not so much time trying to fix the ervices assured the [F-B] that for from staff is not allowed and ident manipulation. Assured ing monitored so it does not on 8/20/14 at 9:40 a.m., the cing Velcro black tape over the R43's television would be hment that resulted in sability to use the television in ould be considered	F 22	6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		245509	B. WING _		08/	/20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 226	facility was monitor LSW-A verified mondone. LSW-A verified mondone. LSW-A verifies staff members in resofthe investigation verified there was rinterviews she comfacility neither as a the audits complete Velcro taped had novolume control of Roccurred to another During an interview administrator stated adult report had be and stated, "Yes, thover the volume cowould be considered in deprivation in R4 in R43's room and maltreatment/abuse a vulnerable adult rand verified the fact abuse prohibition pneed to report alleg designated state as During an interview administrator stated comprehensive interview	ing NA-V on the night shift, the nitoring of NA-V was not being ed she did not interview other gard to this incident as a part process either. LSW-A also to documentation of the pleted with residents in the part of the investigation or of ed of the television to ensure of been placed back over the ed she thought a vulnerable en completed for this incident the placing Velcro black tape entrol of [R43's] television that resulted 3's ability to use the television would be considered en." The administrator stated eport should have been made elility did not follow their facility rotocol which included the ed abuse in this case to the gency.  Ton 8/20/14 at 2:33 p.m., the dishe expected expressed to the gency.  Ton 8/20/14 at 2:33 p.m., the dishe expected expressed to the gency.  Ton 8/20/14 at 2:33 p.m., the dishe expected expressed to the gency.	F 22	26		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245509	B. WING		08	3/20/2014
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 226	with a specific staff verified there was r monitoring or audits	mere was a concern identified member. The administrator to documentation to show the shad been completed.	F 2:	26		
	and PROTECTION  R68 had diagnosis accident and aphas review of the admis (MDS) an assessm review of the same extensive assist of daily living, extensive transfers and toileti	NEGLECT, INVESTIGATION OF RESIDENTS: that included cerebrovascular sia according to document sion Minimum Data Set ent dated 7/2/14. Document MDS identified R68 required one to two staff for activities of reassist of two staff for ng, had short and long term and moderately impaired				
	dated 7/15/14, direct related to cerebrove weakness, requirect transfers and ambubalance. The care	If the facility resident care plan cted R68 had impaired mobility ascular accident, generalized If physical assistance with alation, unsteady gait and plan directed physical assist asfers and had history of self-				
	submitted to the de of Health Facility Co- identified the follow 7/9/14. Maltreatme required assist of o living and transfers transferring self. M the floor, reported t	of facility investigation report signated state agency (Office complaints) dated 7/10/14, ing: Date of incident was ent identified was neglect. R68 ne staff for activities of daily although R68 had history of aintenance staff found R68 on to licensed wing nurse who to the transport of the trans				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245509	B. WING		08/	/20/2014	
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 226	Maintenance felt the nurse neglected to was notified of the of nursing on 7/10/maintenance staff, nursing assistant. On the OHFC repornursing was notified staff and was notified staff and was notified and "Did not see nurse states she was resident." Review of hand written note directed the directed telephone message Director of nursing 8:15 a.m. and state Social Services bed discrepancy. The factor of the nurse had report dated for R68 was delivery person, the evidence that the orinterviewed regarding Document review of Report dated 7/9/14 at 8:05 a.m., the floor. R68 was medical treatment in Document review of dated 7/15/14, iden discussed therapy, pleased with care in the floor of th	respond immediately. LSW-A 7/9/14 incident by the director 14. LSW-A interviewed nurse involved, and one Review of a hand written note at fax sheet revealed director of don 7/9/14 by maintenance and by wing nurse at 8:30 a.m., any discrepancy, because as in the room at 8:05 to help of director of nursing interview lated 7/10/14, at 11:45 a.m., or of nursing received a erabout the fall at 10:00 a.m. stated the message was at add, "I did not report this to cause there was no all occurred at 8:05 am [a.m.] borted it to me by 8:15."  Ince staff indicated the fall as witnessed by the oxygen ere was no documented xygen delivery person was no the incident.  If facility Resident Incident/Fall 4, revealed fall occurred on when janitor reported man on unable to speak and no	F 220				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  G	(X3) DATE COMF	
		245509	B. WING		08/	20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 226	Although the incide a.m., the facility did incident of suspect state agency until 7  During telephone ir a.m., LSW-A stated incident on 7/10/14 the nurse to responshe interviewed the and maintenance s reported that she has then responded to verified no other stainterviewed. LSW-potential neglect with facility or to the During interview on administrator stated incident of potential day.	age 33 Int occurred on 7/9/14, at 8:05 I not immediately report the ed neglect to the designated r/10/14, at 11:35 a.m. Interview on 8/20/14, at 9:40 If she was notified of the LSW-A stated she expected and immediately. LSW-A stated enurse (licensed nurse [LN-A]) taff involved. She stated LN-A and to lock up medications and R68 on the floor. LSW-A aff or residents were A verified the 7/9/14 incident of as not immediately reported to designated state agency.  If 8/20/14, at 3:03 p.m., the dishe was not aware of the I neglect until the following	F 226	DEFICIENCY)		
	of a comprehensive or resident interview and the facility lack LN-A for compliant of an incident like the was no documental protection of R68 deallegation of neglect R1 had diagnosis the demential according admission Minimum assessment dated the same MDS ideallegation of the same ide	further documented evidence investigation, no other staff wed regarding the staff person, ed evidence of monitoring e and to prevent reoccurrence he one with R68. Also there tion provided in regards to the uring the investigation of the ot.  That included heart failure and g to document review of R1's in Data Set (MDS), an 7/24/14. Document review of ontified R1 had severe cognitive quired the assistance of one				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245509	B. WING			08/2	20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP 810 WEST MAIN STREET ADAMS, MN 55909	CODE		
(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 ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E APPROPF	BE	(X5) COMPLETION DATE
F 226	toileting and transfer Document review of dated 8/11/14, direct mobility related to gneeded physical as mobility, transfers, a locomotion.  Document review of submitted to the Off Complaints dated 7 Date of incident was identified was mistroff one for activities and was a high fall report stated on 7/1 R1 state wanted to nursing assistant (Noresponded to R1 by after lunch." According Activities and was a high fall reported the incider identified director of worker (LSW)-A tall a written warning for request of R1, and already received a report stated LSW-off the facility to detect on	daily living which included	F 2	26			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245509	B. WING			08/	20/2014
	PROVIDER OR SUPPLIER	ER		810	EET ADDRESS, CITY, STATE, ZIP CODE WEST MAIN STREET AMS, MN 55909	, ,	
(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 226	to go back to bed."  During telephone ir a.m., licensed socia was aware of the 7 investigated the incomplete was aware of the 7 investigated the incomplete was moved to another stated she had intended to other nursing a shift. LSW-A state investigation and state investigation and state investigation and state incident was were in incident.  Although the investigation, no other interview Not documented evider investigation, no other investigation, no other incident.  Although the investigation, no other incident.  Although the investigation, no other incident.  R6 had diagnosis the incident.  Document review of the same MDS identified staff for toileting and Document review of the same MDS identified staff for toileting and Document review of the same MDS identified staff for toileting and Document review of the same MDS identified staff for toileting and Document review of the same MDS identified staff for toileting and Document review of the same MDS identified staff for toileting and Document review of the same MDS identified staff for toileting and Document review of the same MDS identified staff for toileting and Document review of the same MDS identified staff for toileting and Document review of the same MDS identified staff for toileting and Document review of the same MDS identified staff for toileting and Document review of the same MDS identified staff for toileting and Document review of the same MDS identified staff for toileting and Document review of the same MDS identified staff for toileting and Document review of the same MDS identified staff for toileting and Document review of the same MDS identified staff for toileting and Document review of the same MDS identified staff for toileting and Document review of the same MDS identified staff for toileting and Document review of the same MDS identified staff for toileting and Document review of the same MDS identified staff for toileting and Document re	nterview on 8/20/14, at 9:40 al worker (LSW)-A verified she /18/14 incident with NA-Z, had sident by interviewing NA-Z. measures were put into place on to R1and other residents in stated NA-Z received a verbal atted on resident rights and her wing to work. LSW-A reviewed the activity aide and assistants that worked that d documentation of the taff interviews were located on LSW-A verified no other staff interviewed regarding the digation report included a hand A-Z, the facility had no further note of a comprehensive her staff or resident ing the staff person, and the ence of monitoring the on to prevent reoccurrence of that included diabetes mellitus ling to document review of nimum Data Set (MDS), an 7/17/14. Document review of ontified R6 had severe cognitive quired the assistance of two	F 2	26			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245509	B. WING _		08/	20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 226	staff to assist R6 to bathroom with whe assist, required phybed mobility, transf wheelchair locomotherapy for strength.  Review of facility in Office of Health Fa 7/16/14, identified twas 7/16/14; Maltre mistreatment and rone for activities of was independent wreport identified on coordinator (HUC) requested to use boursing assistant. room later, R6 was been assisted to be (NA-Y) came to R6 and R6 could go in to the bathroom an social services and investigation report interview from HUC investigation report interview with the N was no further documents.	generalized weakness, directed ambulate to and from the eled walker and stand by visical assistance of one for ers, ambulation, and tion, and received physical hening.  Investigation report submitted to cility Complaints dated the following: Date of incident eatment identified was neglect. R6 required assist of daily living and transfers, and with wheelchair mobility. The 7/16/14, health unit entered R6's room, R6 athroom, and HUC notified a When HUC returned to R6's in bed. R6 stated had not athroom, that nursing assistant is and said she was too busy, her pants. HUC assisted R6 d then reported the incident to administrator. The included hand written to administrator. The included a hand written UA-Y and HUC involved, there umented evidence of a estigation and any other staff	F 22	,		
	report dated 7/29/1 of one for activities was occasionally ir own toileting needs	of facility care conference 4, identified R6 required assist of daily living and transfers, accontinent of urine, directed s, and at risk for falls related to fall prior to nursing home.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
	245509	B. WING		08/	/20/2014	
PROVIDER OR SUPPLIER	ER		810 WEST MAIN STREET			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE	
During telephone in a.m., licensed soci was aware of the 7 investigated the incone other nursing a measures were purotection to R6 and LSW-A stated NA-LSW-A stated door and staff interviews report. LSW-A verwere interviewed rewritten interviewed rewritten interview with had no further door comprehensive invesident interviewe and the facility lack NA-Y to prevent re	nterview on 8/20/14, at 9:40 al worker (LSW)-A verified she /16/14 incident with NA-Y, had sident by interviewing HUC and assistant. When asked what it into place to provide ad other residents in the facility, Y was moved to another wing. Immentation of the investigation is were located on the incident ified no other staff or residents egarding the incident. Itigation report included a hand th HUC and NA-Y, the facility immented evidence of a estigation, no other staff or d regarding the staff person, and evidence of abuse when	F 226				
according to docum Minimum Data Set 5/12/14. Documen identified R12 requistaff for activities of toileting and had set Document review of dated 5/27/14, direlights physical mobility re- abnormality, and less	nent review of the quarterly (MDS) an assessment dated at review of the same MDS ired extensive assist of two f daily living, transfers and evere cognitive impairment.  of the facility resident care plan cted R12 had impaired lated to weakness, gait gal blindness and required					
	PROVIDER OR SUPPLIER  SUMMARY STA  (EACH DEFICIENCY REGULATORY OR LE  Continued From pa  During telephone in a.m., licensed social was aware of the 7 investigated the incone other nursing a measures were purprotection to R6 and LSW-A stated NA-LSW-A stated document at a staff interviewed reference interviewed reference interviewed reference interviewed reference and the facility lack NA-Y to prevent reference a	PROVIDER OR SUPPLIER  HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 37  During telephone interview on 8/20/14, at 9:40 a.m., licensed social worker (LSW)-A verified she was aware of the 7/16/14 incident with NA-Y, had investigated the incident by interviewing HUC and one other nursing assistant. When asked what measures were put into place to provide protection to R6 and other residents in the facility, LSW-A stated NA-Y was moved to another wing. LSW-A stated documentation of the investigation and staff interviews were located on the incident report. LSW-A verified no other staff or residents were interviewed regarding the incident.  Although the investigation report included a hand written interview with HUC and NA-Y, the facility had no further documented evidence of a comprehensive investigation, no other staff or resident interviewed regarding the staff person, and the facility lacked evidence of monitoring NA-Y to prevent reoccurrence of abuse when moved to another unit who had vulnerable	PROVIDER OR SUPPLIER  HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 37  During telephone interview on 8/20/14, at 9:40 a.m., licensed social worker (LSW)-A verified she was aware of the 7/16/14 incident with NA-Y, had investigated the incident by interviewing HUC and one other nursing assistant. When asked what measures were put into place to provide protection to R6 and other residents in the facility, LSW-A stated NA-Y was moved to another wing. LSW-A stated documentation of the investigation and staff interviews were located on the incident report. LSW-A verified no other staff or residents were interviewed regarding the incident.  Although the investigation report included a hand written interview with HUC and NA-Y, the facility had no further documented evidence of a comprehensive investigation, no other staff or resident interviewed regarding the staff person, and the facility lacked evidence of monitoring NA-Y to prevent reoccurrence of abuse when moved to another unit who had vulnerable residents.  R12 had diagnosis that included dementia according to document review of the quarterly Minimum Data Set (MDS) an assessment dated 5/12/14. Document review of the same MDS identified R12 required extensive assist of two staff for activities of daily living, transfers and toileting and had severe cognitive impairment.  Document review of the facility resident care plan dated 5/27/14, directed R12 had impaired physical mobility related to weakness, gait abnormality, and legal blindness and required	PROVIDER OR SUPPLIER  #EALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 37  During telephone interview on 8/20/14, at 9:40 a.m., licensed social worker (LSW)-A verified she was aware of the 71/61/4 incident with NA-Y, had investigated the incident by interviewing HUC and one other nursing assistant. When asked what measures were put into place to provide protection to R6 and other residents in the facility, LSW-A stated documentation of the investigation and staff interviews were located on the incident report. LSW-A verified no other staff or residents were interviewed regarding the staff person, and the facility lacked evidence of a comprehensive investigation, no other staff or resident interview with HUC and NA-Y, the facility had no further documented evidence of a comprehensive investigation, no other staff or resident interviewed regarding the staff person, and the facility lacked evidence of monitoring NA-Y to prevent reoccurrence of abuse when moved to another unit who had vulnerable residents.  R12 had diagnosis that included dementia according to document review of the quarterly Minimum Data Set (MDS) an assessment dated 5/12/14. Document review of the same MDS identified R12 required extensive assist of two staff for activities of daily living, transfers and toileting and had severe cognitive impairment.  Document review of the facility resident care plan dated 5/27/14, directed R12 had impaired physical mobility related to weakness, gait abnormality, and legal blindness and required	REQUIDER OR SUPPLIER  HEALTH CARE CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, NN 55909  REQUIDER OR LISC IDENTIFYING INFORMATION)  REGULATORY OR LISC IDENTIFYING INFORMATION)  Continued From page 37  Continued From page 37  During telephone interview on 8/20/14, at 9:40 a.m., licensed social worker (LSW)-A verified she was aware of the 7/16/14 incident with NA-Y, had investigated the incident by interviewing IHUC and one other nursing assistant. When asked what measures were put into place to provide protection to R6 and other residents in the facility, LSW-A stated NA-Y was moved to another wing.  LSW-A stated AN-Y was moved to another wing.  LSW-A stated verified no other staff or residents were interviewed regarding the incident and staff interviews were located on the incident report. LSW-A verified no other staff or residents were interviewed regarding the staff person, and the facility lacked evidence of a comprehensive investigation, no other staff or resident interviewed regarding the staff person, and the facility lacked evidence of monitoring NA-Y to prevent reoccurrence of abuse when moved to another unit who had vulnerable residents.  R12 had diagnosis that included dementia according to document review of the quarterly Minimum Data Set (MDS) an assessment dated 5/12/14. Document review of the same MDS identified R12 required extensive assist of two staff for activities of daily living, transfers and toileting and had severe cognitive impairment.  Document review of the facility resident care plan dated 5/27/14, directed R12 had impaired physical mobility teletated to weakness, gait abnormality, and legal blindness and required	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245509	B. WING _		08	/20/2014
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909	, 33.	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 226	oriented to self and memory impairmer 5/27/14, directed elimination, frequer bladder, required e transfer to and from Document review of submitted to Office (OHFC) dated 7/21 Date of incident was identified was negle required assistance activities of daily live two staff for transfer with mechanical lift R12 was found on floor from an old ell nursing and adminical plan had not been to the incident details 7/21/14, revealed of and had not been to hours. Care plan we supposed to be toil shift instructed to cup for the day, as Found on floor, fall foun	I had short and long term Int. The care plan dated R12 had alteration in Intly incontinent of bowel and Interest assist of two to In the toilet with mechanical lift. In facility investigation report In facility resident	F 2:	26		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245509	B. WING		08/	20/2014
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909	,	
(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
F 226	Continued From page 39 activities or behaviors, was last toileted at 2:40		F 220	6		
		complaints, no environmental				
	report dated 5/27/1	f facility care conference 4, identified R12 was I and bladder and staff to eds.				
	a.m., licensed social was aware of the 7, verified R12 was or provide cares. She provided cares or to she had interviewed assistant on that she educated NA-X on NA-X to provide ca	aterview on 8/20/14, at 9:40 al worker (LSW)-A verified she /21/14 incident. LSW-A the care list for night shift to everified NA-X had not bileted R12. LSW-A stated d NA-X and one other nursing lift. LSW-A stated she had R12's care plan and reminded res on last rounds. LSW-A aff or residents were				
	of a comprehensive or resident interview and the facility lack					
	according to docum Minimum Data Set 7/17/14. Documen identified R20 requ two staff for activities	that included diabetes mellitus nent review of the annual (MDS) an assessment dated t review of the same MDS ired extensive assist of one to es of daily living, extensive or transfers and toileting, and litive impairment.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245509	B. WING _		08	/20/2014
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CO 810 WEST MAIN STREET ADAMS, MN 55909	•	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORE ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 226	dated 7/29/14, dire mobility related to a physical assistance one assist, and one out of bed.  Document review of submitted to the O Complaints dated & Date of incident was identified was verb two staff assist for family (F-A) membrassistant (NA-W) is cursed at R20 where up. LSW-A, direct of interviewed NA-W. residents who were and there were no behavior is being no finursing and admit Document reviewed dated 8/5/14; identificated diet and man further concerns.  During telephone in a.m., LSW-A state incident.	of the facility resident care plan ected R20 had impaired right sided weakness, required e with mobility, transfer with a assist getting resident in and of facility investigation report expected frice of Health Facility 8/6/13, identified the following: as 8/2/13. Maltreatment all abuse. R20 required one to transfers. R20 reported to er on 8/6/13, that a nursing ead been verbally rude and en R20 asked for help to stand or of nursing and administrator. LSW-A interviewed other even the care list for the NA-W complaints. Nursing assistant monitored by LSW-A, director expected in the care conference note ified R20 and family discussed redications and then had no enterview on 8/20/14 at 9:40 d she did not remember the tated she expected staff to to residents.  further documented evidence expected ing the staff person, and the ence of monitoring the NA-W to note and that verbal abuse	F 2:	26		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG	` '	(X3) DATE SURVEY COMPLETED	
		245509	B. WING _		08	/20/2014	
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909			
(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 SHOUTH CORRESTIVE ACTION SHOUTH CORREST PROVIDER TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 226	R25's admission M 7/14/14 indicated R mental status (BIMS impairment and rec two for bed mobility assistance of one for personal hygiene. indicated R25 was and place. Confusi short term memory simple decisions in guidance from fami decisions." During an interview reported that a nurs room to answer his asked the nursing a light off because it y nursing assistant to light on to see to wo nursing assistant to light on until they tu to R25 the nursing a that if he continued would "Piss!" her of stated that this hap During an interview worker (LSW)-A 8/1 stated she was not On 8/13/14 at 11:00 R25 and LSW-A, R nursing assistant w would get pissed of keep putting his cal During an interview 9:20 a.m., LSW-A v interview other staff as part of the invest	inimum Data Set (MDS) dated 25 had a brief interview for S) of 5, which indicated severe uired extensive assistance of and toileting, and extensive or dressing, eating, and The care plan dated 7/24/14 delet and oriented to person on with time/dates and some impairments. Able to make dependently. Requires ly and staff with healthcare  on 8/11/14 at 4:25 p.m. R25 sing assistant came into his light about 4:00 a.m. and R25 assistant to turn the hallway was keeping him up. The lid him they had to keep the ork. R25 stated he told the ewould keep putting his call rned the light off. According assistant replied back to him to put his call light on that it f an in not a nice tone. R25 pened last week. with the licensed social 12/14 at 3:30 p.m., the LSW-A aware of this incident. 0 a.m. during an interview with 25 stated that it was a female ith a pony tail that told him she f when he stated he would	F 22	26			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		245509	B. WING		8/20/2014	
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	LSW-A did not indic documentation they measures that had reoccurrence of the resident.	cate or have any y provided any protective been put into place to prevent incident for R25 or any other	F 226			
F 241 SS=E	The facility must promanner and in an eenhances each res	omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.	F 241		9/17/14	
	by: Based on interview facility failed to ens R6, R12, R20, R25 neglect incidents, widignity.  This had the potent who resided in the Findings include:  RESIDENT RIGHT	,		It is the policy of Adams Health Care Center to treat residents with respect an dignity. All residents of Adams Health Care center will be treated as such. A comprehensive investigation will be conducted on all incidents and will be documented. Involved staff will be monitored to determine compliance.  Resident Rights Policy and Accidents ar Incidents Investigating and Reporting reviewed at an All Staff meeting on 09/17/2014.		
	" Policy statement: residents with kindr 3. Our facility will m resident in exercising the resident is alway kindness and dignit. The resident bill of	Employees shall treat all ness, respect, and dignity ake every effort to assist eaching his/her rights to ensure that ys treated with respect,		Random audits will be conducted once per week for one month and once per month for 3 months to monitor for compliance. Social Services Director, DON, Administrator and/or their designer are responsible to monitor for compliance. Results will be forwarded to QA/QI		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245509	B. WING			08/2	20/2014
	VIDER OR SUPPLIER	ER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET ADAMS, MN 55909	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
yo or red DI Du dir sta an co wh LIG Du a.r res ST Do tra sta the 3/r an im ex lim su loo inco pe an to	enhances your decognition of your RECTOR OF NUtring an interview rector of nursing (aff to treat residered dignity. The DO ompleted with staffnen interacting and CENSED SOCIAL uring telephone in m., LSW-A stated spectfully to reside aff involved in the etraining and one of the treatment with clear the completed R14/14.  18's quarterly Min 10/14 revealed R and Depression. Rate of the completed assist of one operation with one comotion. The calcicated R18 was, erson and place and dates. Is able to make simple decognition of the complete residence and dates. Is able to make simple decognition of the complete residence and dates. Is able to make simple decognition of the calcicated R18 was, and dates. Is able to make simple decognition of the calcicated R18 was, and dates. Is able to make simple decognition of the calcicated R18 was, and dates. Is able to make simple decognition of the calcicated R18 was, and dates. Is able to make simple decognition of the calcicated R18 was, and dates. Is able to make simple decognition of the calcicated R18 was, and dates. Is able to make simple decognition of the calcicated R18 was, and dates. Is able to make simple decognition of the calcicated R18 was, and dates. Is able to make simple decognition of the calcicated R18 was, and dates.	d environment that maintains ignity and respect in full individuality."  IRSING EXPECTATIONS: on 8/14/14 at 10:31 a.m., the (DON) stated she expected into in the building with respect DN stated education had been if regarding their approach and caring for residents.  L WORKER EXPECTATIONS: atterview on 8/20/14 at 9:40 is she expected staff to speak lents.	F 2	41	Committee for review and further recommendation.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245509	B. WING		_	08/20/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST. 810 WEST MAIN STREET ADAMS, MN 55909	•	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
F 241	concern to her reg the television not we the facility went ho returned to the fac remote and the rer went to look at the piece of black Velocontrol. F-B then a removed the tape the concerns related approach with R18 conference held in facility staff apolog with R18's television F-B also stated at concerns with staff stated was told by have an approach and he may percei help him. Stated sl	age 44 014 when R18 voiced a arding the remote control for vorking. FM-B stated F-B left me and got new batteries, ility, placed new batteries in the mote still did not work. FM-B controls on the there was a tro tape over the volume lerted staff to this concern and from the television. F-B stated ded to the television and staff were discussed at the care July of this year. F-B stated ized and stated the incident on should not have happened. care conference when approach was discussed, the facility some of their staff that is rough around the edges we this as staff not wanting to ne was told the facility was oproach on how to speak to	F 2	41		
	7/25/14 progress nabout the incident being placed on the Resident's TV. The visit resident one avolume was so low the remote didn't' was batteries from hom them in the remote [F-B] then went up control button, at was Velcro. [F-B] states this and took the Verside of the remote of t	ce progress noted dated note read, "Family then asked regarding a Velcro adhesive e volume receptor on a [F-B] states [F-B] came to fernoon and asked why his TV or. Resident reported to her that work, so the [F-B] left to go get the. [F-B] returned and placed a and states it still did not work, to the TV to find a volume or which time [F-B] found the a [F-B] was caught off guard by the [F-B] that this incident had				

The state of the s		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		245509	B. WING		08/	/20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 241	Administrator, DON staff responsible for The [F-B] then state problems with gettin down. I was frustrathad spent so much Social Services assibehavior from staff considered residenthat this is being magain"  During an interview licensed social worknot treated with restaff member place control on the televication on the televication on the televication had been and dignity. The DO treated with respectatiff member place control on the televication had been approach when interesidents.  R1 had diagnosis the dementia according admission Minimum assessment dated the same MDS idenimpairment and registaff for activities of toileting and transfer	th to the attention of the land Social Services and the radion this had been talked to. ed, 'Well I know there are not him to keep his volume need when I found it because I time trying to fix the remote.' sured the [F-B] that this kind of its not allowed and it is a manipulation. Assured her conitored so it does not happen on 8/14/14 at 8:21 a.m., the ker (LSW)-A verified R18 was pect and dignity when a facility divelor tape over the volume sion.  on 8/14/14 at 10:31 a.m., the DON) stated she expected has in the building with respect to the conflict of the pool of	F 2	41		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245509	B. WING _		08/	20/2014
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 241	Continued From pa	age 46	F 24	1		
	dated 8/11/14, direct mobility related to go needed physical as mobility, transfers, locomotion.  Document review of submitted to the Off Complaints dated 7 Date of incident was identified was misted of one for activities and was a high fall report stated on 7/1 R1 state wanted to nursing assistant (Iff responded to R1 by after lunch." According request of R1, and already received a report stated LSW-off the facility to det concerns or complead though the invest written interview Nadocumented evider investigation and a interviews.	cted staff R1 had impaired generalized weakness, and sistance of one for bed ambulation, and wheelchair of facility investigation report ffice of Health Facility 7/18/14, identified the following: 87/18/14, Maltreatment reatment. R1 required assist of daily living and transfers, risk due to unsteady gait. The 18/14, activity aid overheard lay down. Activity aid notified NA)-Z on that wing who y saying " can't lay down until rding to the report, activity aid not to supervisor. The report of nursing and licensed social liked with NA-Z. NA-Z received or failure to respond to the it was learned that NA-Z had verbal warning that week. The A would visit with " residents ermine if there are any aints relating to" staff member. Itigation report included a hand A-Z, there was no further noce of a comprehensive my further staff or resident				
		nterview on 8/20/14, at 9:40 al worker (LSW)-A verified she				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245509	B. WING _		08	/20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 241	investigated the inc When asked what it to provide protection the facility, LSW-A warning, was educa was moved to anot stated she had inte two other nursing a shift. LSW-A state investigation and st the incident report. or residents were in incident.  Although the invest written interview NA documented evider investigation, no of interviewed regardi facility lacked evider	Interviewed that documentation of the staff interviewed regarding the staff or resident on LSW-A verified no other staff interviewed regarding the staff or resident on LSW-A verified no other staff interviewed regarding the staff or resident included a hand A-Z, the facility had no further not of a comprehensive her staff person, and the ence of monitoring the on to prevent reoccurrence of	F 24	11		
	and arthritis accord R6's admission Mir assessment dated the same MDS ider impairment and red staff for toileting an					
	dated 7/29/14, direct mobility related to go staff to assist R6 to bathroom with whe	of facility resident care plan cted staff R6 had impaired generalized weakness, directed ambulate to and from the eled walker and stand by visical assistance of one for				

AND DLAN OF CODDECTION IDENTIFICATION NUMBED:		TIPLE CONSTRUCTION	(	(X3) DATE SURVEY COMPLETED			
		245509	B. WING			08/2	20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CO 810 WEST MAIN STREET ADAMS, MN 55909	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD E	3E	(X5) COMPLETION DATE
F 241	wheelchair locomot therapy for strength Review of facility in Office of Health Fac 7/16/14, identified the was 7/16/14, identified the was 7/16/14; Maltre mistreatment and none for activities of was independent wreport identified on coordinator (HUC) requested to use be nursing assistant. Troom later, R6 was been assisted to be (NA-Y) came to R6 and R6 could go in to the bathroom and social services and investigation report interview from HUC investigation report interview with the N was no further document review or resident interview or resident interview or resident interview or social services and investigation report interview or resident interview or resident interview or resident interview or activities was occasionally in own toileting needs unsteady gait and family in the properties of the properties o	ers, ambulation, and ion, and received physical iening.  vestigation report submitted to cility Complaints dated he following: Date of incident eatment identified was eglect. R6 required assist of daily living and transfers, and ith wheelchair mobility. The 7/16/14, health unit entered R6's room, R6 athroom, and HUC notified a When HUC returned to R6's in bed. R6 stated had not athroom, that nursing assistant and said she was too busy, her pants. HUC assisted R6 d then reported the incident to administrator. The included hand written and NA-Y. Although the included a hand written A-Y and HUC involved, there umented evidence of a estigation and any other staff	F 2	.41			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245509	B. WING		08	3/20/2014	
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909			
(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 SHOOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 241	one other nursing a measures were put protection to R6 and LSW-A stated NA-N LSW-A stated docu and staff interviews report. LSW-A veriwere interviewed resulting and the facility lack NA-Y to prevent resident interviewed and the facility lack NA-Y to prevent residents.  R12 had diagnosis according to docum Minimum Data Set 5/12/14. Document identified R12 requistaff for activities of toileting and had see Document review odated 5/27/14, direct oriented to self and memory impairment 5/27/14, directed F1/27/14, directed F1/	ge 49 ident by interviewing HUC and ssistant. When asked what into place to provide dother residents in the facility, was moved to another wing. mentation of the investigation were located on the incident fied no other staff or residents garding the incident.  Igation report included a hand h HUC and NA-Y, the facility imented evidence of a estigation, no other staff or diregarding the staff person, ed evidence of monitoring occurrence of abuse when init who had vulnerable  Ithat included dementia ment review of the quarterly (MDS) an assessment dated that review of the same MDS red extensive assist of two daily living, transfers and overe cognitive impairment.  If the facility resident care plan ated R12 had impaired ated to weakness, gait gal blindness and required staff to reposition, and ee hours. The care plan ated R12 was alert and had short and long term to the care plan dated R12 had alteration in atly incontinent of bowel and	F 2	41			

	OF DEFICIENCIES OF CORRECTION				(X3) DATE SURVEY COMPLETED	
		245509	B. WING		08/	/20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CO 810 WEST MAIN STREET ADAMS, MN 55909	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 241	transfer to and from  Document review of submitted to Office (OHFC) dated 7/21 Date of incident was identified was negle required assistance activities of daily live two staff for transfer with mechanical lift R12 was found on floor from an old elenursing and adminisplan had not been the incident details 7/21/14, revealed of and had not been thours. Care plan we supposed to be toil shift instructed to out for the day, as Fernoring hours and out of bed.  Document review of incident/fall report of found on floor, fall thematoma opened.  Document review of investigation works 7/21/14, revealed Fernoring on, was last of activities or behavior and out of behavior of the day of the matoma opened.	Attensive assist of two to a the toilet with mechanical lift.  If facility investigation report of Health Facility Complaints /14, identified the following: s 7/21/14, Maltreatment etc. R12 was legally blind, of one staff person for all ing, required assist of one to irs, and at times is transferred. On 7/21/14, at 6:25 a.m., the floor by bed, blood on the bow hematoma. Director of strator determined R12's care followed. Document review of submitted to OHFC dated ares had not been completed oileted within the last four iras not followed as R12 was eted every two hours and night omplete R12's cares and get R12 is restless in the early had a history of trying to get	F 2	241		

NAME OF PROVIDER OR SUPPLIER  ADAMS HEALTH CARE CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  810 WEST MAIN STREET  ADAMS, MN 55909  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION		COMPLETED		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	T OF DEFICIENCIES DF CORRECTION	
NAME OF PROVIDER OR SUPPLIER  ADAMS HEALTH CARE CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  810 WEST MAIN STREET  ADAMS, MN 55909  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	08/20/2014	08/20/2014		NG	В. \	245509		
(7.1) 15			10 WEST MAIN STREET	81	•	ER		
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 DEFICIENCY)	(X5) COMPLETION DATE	E COMPLET	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR	FIX	F	/ MUST BE PRECEDED BY FULL	(EACH DEFICIENC)	PRÉFIX
Continued From page 51 Document review of facility care conference report dated 5/27/14, identified R12 was incontinent of bowel and bladder and staff to anticipate R12's needs.  During telephone interview on 8/20/14, at 9:40 a.m., licensed social worker (LSW)-A verified she was aware of the 7/21/14 incident. LSW-A verified R12 was on the care list for night shift to provide cares. She verified NA-X had not provided cares or toileted R12. LSW-A stated she had interviewed NA-X and one other nursing assistant on that shift. LSW-A stated she had educated NA-X on R12's care plan and reminded NA-X to provide cares on last rounds. LSW-A verified no other staff or residents were interviewed.  The facility had no further documented evidence of a comprehensive investigation, no other staff or resident interviewed regarding the staff person, and the facility lacked evidence of monitoring NA-X to determine compliance in meeting resident needs/treatments to prevent reoccurrence of neglect.  R20 had diagnosis that included diabetes mellitus according to document review of the annual Minimum Data Set (MDS) an assessment dated 7/17/14. Document review of the same MDS identified R20 required extensive assist of one to two staff for activities of daily living, extensive assist of one staff for transfers and toileting, and had moderate cognitive impairment.  Document review of the facility resident care plan dated 7/29/14, directed R20 had impaired mobility related to right sided weakness, required				- 241	,	of facility care conference 4, identified R12 was el and bladder and staff to eds.  Interview on 8/20/14, at 9:40 al worker (LSW)-A verified she //21/14 incident. LSW-A in the care list for night shift to everified NA-X had not colleted R12. LSW-A stated d NA-X and one other nursing lift. LSW-A stated she had R12's care plan and reminded res on last rounds. LSW-A aff or residents were  further documented evidence e investigation, no other staff wed regarding the staff person ed evidence of monitoring compliance in meeting thments to prevent glect.  that included diabetes mellitus nent review of the annual (MDS) an assessment dated t review of the same MDS ired extensive assist of one to les of daily living, extensive or transfers and toileting, and litive impairment.  of the facility resident care plan lected R20 had impaired	Document review or report dated 5/27/1 incontinent of bowe anticipate R12's new During telephone in a.m., licensed social was aware of the 7 verified R12 was on provide cares. She provided cares or to she had interviewed assistant on that she educated NA-X on NA-X to provide caverified no other stainterviewed.  The facility had no of a comprehensive or resident interviewed and the facility lack NA-X to determine resident needs/treareoccurrence of new R20 had diagnosis according to docum Minimum Data Set 7/17/14. Document identified R20 requitive staff for activities assist of one staff for had moderate cogridated 7/29/14, directions of the staff o	F 241

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245509	B. WING _		08/	20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909	•	
(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 APPROPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 241	out of bed.  Document review of submitted to the Of Complaints dated 8 Date of incident was identified was verbat two staff assist for family (F-A) members assistant (NA-W) hoursed at R20 when up. LSW-A, director interviewed NA-W. residents who were and there were not behavior is being more for nursing and admitted and more further concerns.  During telephone in a.m., LSW-A stated incident. LSW-A stated incide	f facility investigation report fice of Health Facility 16/6/13, identified the following: 8 8/2/13. Maltreatment all abuse. R20 required one to transfers. R20 reported to the ron 8/6/13, that a nursing and been verbally rude and in R20 asked for help to stand or of nursing and administrator LSW-A interviewed other on the care list for the NA-W complaints. Nursing assistant anonitored by LSW-A, director inistrator.  If facility care conference note fied R20 and family discussed edications and then had no atterview on 8/20/14 at 9:40 ashe did not remember the ated she expected staff to to residents.  Further documented evidence investigation, no other staffing the staff person, and the ence of monitoring the NA-W to note and that verbal abuse	F 24			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245509	B. WING _		08/	20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909		
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F 241	assistance of one find personal hygiene. Indicated R25 was and place. Confus short term memory simple decisions in guidance from fam decisions."  During an interview reported that a nurroom to answer his asked the nursing light off because it nursing assistant to light on to see to wind nursing assistant hight on until they to to R25 the nursing that if he continued would "Piss!" her ostated that this hap During an interview worker (LSW)-A 8/stated she was not On 8/13/14 at 11:00 R25 and LSW-A, Rinursing assistant wind get pissed of keep putting his cal During an interview worker and interview worker that the same continued that the same continue	y and toileting, and extensive or dressing, eating, and The care plan dated 7/24/14 "alert and oriented to person ion with time/dates and some impairments. Able to make dependently. Requires ily and staff with healthcare on 8/11/14 at 4:25 p.m. R25 sing assistant came into his alight about 4:00 a.m. and R25 assistant to turn the hallway was keeping him up. The old him they had to keep the ork. R25 stated he told the e would keep putting his call urned the light off. According assistant replied back to him to put his call light on that it ff an in not a nice tone. R25 spened last week. If with the licensed social 12/14 at 3:30 p.m., the LSW-A aware of this incident. Of a.m. during an interview with the stated that it was a female with a pony tail that told him she ff when he stated he would	F 24	, , , , , , , , , , , , , , , , , , ,		
	as part of the inves allegation of verbal LSW-A did not indi- documentation the measures that had	f members or other residents stigation process when this abuse was told to her. cate or have any y provided any protective been put into place to prevent e incident for R25 or any other				

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F 241 F 272 SS=D	ASSESSMENTS  The facility must coa a comprehensive, a reproducible asses functional capacity.  A facility must make assessment of a reresident assessme by the State. The aleast the following: Identification and docustomary routine; Cognitive patterns; Communication; Vision; Mood and behavior Psychosocial well-behavior Psychosocial well-behavio	PREHENSIVE  Induct initially and periodically accurate, standardized sment of each resident's  Induct initially and periodically accurate, standardized sment of each resident's  Induct initially and periodically accurate, standardized sment of each resident's  Induct initially and periodically accurate, standardized sment include at sident's needs, using the not instrument (RAI) specified assessment must include at emographic information;  In patterns; In	F 2			9/17/14	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 272	Continued From pa	age 55	F 272	2		
	by: Based on interview facility failed to con assessment for elo (R43) reviewed for Findings Include: R43 's Medical red been no elopement even though R43 h R43's admission rediagnoses of bipola obsessive compuls history of traumatic change Minimum Dindicated R43 had status (BIMS) scorrimpairment.  Review of incident eloped from the fact 4/10/14 and 6/3/14 Resident Incident FR43 had an unwith p.m., "Resident w [R43] pushed the different door of the fact with resident down returned to the fact the parking lot." Im	cord review revealed there had a risk assessments completed and a history of elopement/s. ecord identified R43 had ar disorder, schizophrenia, sive personality disorder, and a brain injury. R43's significant Data Set (MDS) dated 5/7/14 a brief interview for mental e of 14 indicating no cognitive reports revealed R43 had cility on 4/1/14, 4/7/14, 4/8/14,		R43 has not made any attempts to the facility grounds since the responanty (sister) has requested that R4 allowed to go outside independent 08/29/2014. R43 is no longer consist an elopement risk and the responsion party concurs with this, however structure to monitor R43's whereast provide supervision and safety. A comprehensive assessment for elopement will be done for all resid Adams Health Care Center on admand as needed.  The Elopement Risk Policy was rest an All Staff meeting on 09/17/20. Audits will be conducted on admissionand periodically thereafter to monit compliance. Social Services, DON Administrator and/or their designed responsible to monitor for compliant. Results will be forwarded to QA/QI Committee for review and further recommendation.	ensible 43 be y since idered ible aff will routs to  ents of nission  viewed 14.  sion or for e are nce.	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			E SURVEY MPLETED
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F 272	was orientated to p "Resident to be in h go outside with resi Resident Incident F R43 had an unwith a.m., "Resident pu proceeded to go ou to prevent further in completed on the in status: indicated R4 to assist outside if   12:16 p.m. the licer	ental status: indicated R43 erson and was forgetful. Plan: highly visible area. Staff is to ident for walks when able."  Report dated 4/7/14 indicated essed elopement. At 11:00 ushed door alarm and at front door." Immediate action highly to resident: was not hocident report. Prior Mental 43 was forgetful. Plan: "Staff (R43] wishes." On 8/13/14 at hised social worker (LSW)-A t report did not include, how	F 27	2		
	staff was alerted to R43 was outside, or into the facility.  Resident Incident FR43 had an unwith p.m., " staff reported without w/c [wheeled the end of the side Immediate action to resident: indicated "Prior Mental status Plan: remind reside outside. On 8/13/14 the incident reported alerted to R43 beindoutside, or how R44 facility.  Resident Incident FR43 had an unwith p.m., " staff noted entrance after the control of the status of	R43 being outside, how long or how R43 was brought back. Report dated 4/8/14 indicated essed elopement. At 4:50 ed resident was outside chair] or walker. Had made it to walk from the front entrance." to prevent further injury to removed to place of safety. Si indicated R43 was forgetful. ent to ask staff before going 4 at 12:16 p.m. LSW-A verified did not include, how staff was g outside, how long R43 was 3 was brought back into the Report dated 4/10/14 indicated essed elopement. At 8:20 res [resident] leaving front door alarm had sounded. Had elf and had made it to the				

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
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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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 272	parking lot." Immerinjury to resident: ir safety. Prior Menta forgetful. Plan: "reroutside or have sta [Interdisciplinary tesafety/elopement, flike to see more incoutside independer when decision is multiple of the indicated R43 had a 7:10 p.m., "Visitor supposed to be out ft. [feet] away from	ediate action to prevent further indicated removed to place of all status: indicated R43 was mind resident to ask to go ff go outside with resident. IDT am] to meet [with] concerns for amily member (FM)-A would dependence [with] going intly. Will update care plan		772			
	circle the block and action to prevent fur indicated education indicated R43 was and confused. Plant that [R43] needs so goes outside."  On 8/14/14 at 9:34 facility does not con assessments for re	I then come back." Immediate orther injury to resident:  a." Prior Mental status: orientated to person, forgetful or continue to remind [R43] ormeone with him when he  a.m., LSW-A stated, " the or mplete elopement or sidents. Once a resident					
	considered a risk for the wandering book meetings and deter go outside on their based on staffs' op can be outside una her opinion on the constant of the staff o	without telling staff, they are or elopement and are added to c. From there we talk in IDT rmine whether a resident can own." LSW-A stated it was " inion as to whether a resident ttended and stated she based cognition of the resident."  5 a.m. the director of nursing elopement assessment is					

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F 272	The DON verified s completed elopement medical record and assessment had be DON stated staff shelopement assessmevery resident and be made to determ elopement had chastay.  An Elopement Risk follows:  Definition of Elopement Any resident attemp without the assistant determined as atterned as atterned as atterned as atterned to the rights and facility maintains a prevention strategie elopement risk, instituted in the time of admission resident procedure.  Procedure  1. All entrances to the system in place.  2. Staff will be educed.	resident upon admission." he was unable to find a ent assessment for R43 in his stated an elopement een added on 8/14/14. The hould be completing an nent upon each admission for verified reassessments should ine if residents risk for nged during the course of their  policy dated 3/2011 read as  nent oting to exit the building nce of family will be mpted elopement.  o promote resident safety and and dignity of the residents. The process to implement es for those identified as an titute measures for resident used in the Wandering book at on, and conduct a missing	F 27			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION (2	(3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909	
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F 272 F 276 SS=D	4. Residents who han elopement risk to the facility wands 5. Residents at risk elopement care pla 6. Staff will complete plan in the event that the facility and cannot result the facility must assequant result of residents and approved by Conce every 3 months.  This REQUIREMED by:  Based on interview facility failed to reason of 3 residents (R2 Findings include:  R21 had been admits the facility failed to reason of the facility failed to rea	whereabouts of residents at ave been identified as being will have their profile added ering book.  for elopement will have an n in place te a missing resident action at a resident has eloped from not be located ments of residents will be teeting and interventions ERLY ASSESSMENT AT HONTHS  ss a resident using the trument specified by the State MS not less frequently than	F 276		nts of different
	7/18/14, identified	Data Set (MDS) dated but not limited to diagnoses of in 's disease, heart failure,		Fall Risk Assessment Observation F were reviewed at a Licensed Nurses meeting on 09/17/2014.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245509	B. WING			08/2	20/2014
	PROVIDER OR SUPPLIER	ER		8	STREET ADDRESS, CITY, STATE, ZIP CODE B10 WEST MAIN STREET ADAMS, MN 55909		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 276	and required extens transfers.  Document review of start date 5/30/14, if falling related to impassistance to safely interventions of keet a Dycem gripper under the properties of the propertie	pulmonary disease (COPD) sive assist two persons for f R21's care plan problem dentified problem: at risk for paired mobility, requires staff or transfer to/from surfaces with up call light in reach and place ader cushion of wheel chair.  If R21's resident profile dated ut not limited to falls: keep call f R21's records identified last evaluation had been dated ed a score of 20 (a resident higher is at risk).  If R21's fall risk had not been is quarterly review MDS dated view of R21's record	F 2	?76	Audits will be conducted periodicall admission, quarterly and randomly monitor for compliance. DON, SD, Coordinator are responsible to mor compliance.  Results will be forwarded to QA/QI Committee for review and further recommendation.	to MDS	
F 282	assessment. 483.20(k)(3)(ii) SEF	RVICES BY QUALIFIED	F 2	82			9/17/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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must be provide	. •	F 282			
by: Based on observation order oxygen to oxygen saturation by: Based on observation by: Based on observation oxygen by: Based on observation oxygen saturation order oxygen to oxygen saturation order oxygen by: Based on observation oxygen administration oxygen saturation oxygen saturation order oxygen by: Based on observation oxygen administration oxygen saturation oxygen saturation oxygen oxygen by: Based on observation oxygen administration oxygen oxygen by: Based on observation oxygen administration oxygen	MENT is not met as evidenced ervation, interview and document ty failed to follow the care plan for tration for 1 of 3 residents (R21) spiratory care; failed to follow the ill care for 1 of 3 residents (R21) tivities of daily living; failed to plan for fall interventions for 1 of 3 reviewed for accidents and failed to plan for skin for 2 of 3 residents ewed for skin conditions.  Exact admitted on 4/11/14 according to Minimum Data Set (MDS) dated fied but not limited to diagnoses of inson 's disease, heart failure and tive pulmonary disease (COPD). To orders dated 7/16/14, identified to liters via nasal cannula to keep on equal to or less than 90 tion on 8/11/14, at 6:58 p.m., R21 m sitting in wheelchair, a portable I been hanging on the back of R21		All care plans will be followed for residents of Adams Health Care (An inservice education was held of 09/17/2014 to review the process following care plans for all resider Audits will be conducted once per for one month and once per month months to monitor for compliance SD, MDS Coordinator are responsition for compliance.  Results will be forwarded to QA/C Committee for review and further recommendation.	Center.  on     of     nts.  r week th for 3 e. DON, sible to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	C	(X3) DATE SURVEY COMPLETED 08/20/2014	
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	PROVIDER OR SUPPLIER HEALTH CARE CEN			STREET ADDRESS, CITY, STATE, ZIP C 810 WEST MAIN STREET ADAMS, MN 55909	ODE	00/2	.0/2017
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F 282	the unit read emptremaining. R21 's reach of R21 and on R21 's bed and not been visible. It hands had been low underneath all fing on top of left hand R21 had stated at breathing. Surveyous assistant (NA)-E at light was not in read oxygen unit tank in disconnected R21 R21 's portable tat a standing tank of set the dial at threath tank and then NA-Surveyor interview how knows how in the receiving and Note are plan in the construction of R21's care plan in plan read R21 was liters. NA-E verified liters and went back changed the dial to liquid oxygen tank.  During observation had been sitting in bruise on top of leftinger, purple in considerable between the considerable in the considerable oxygen tank.  During observation had been sitting in bruise on top of leftinger, purple in considerable in the considerable oxygen tank.	y for amount of oxygen in the call light had not been in had been wrapped in a blanket of the end of the call light had it the end of the call light had bruise between thumb and first finger. The time he had no difficulty or alerted staff and nursing it the time verified R21's call each for R21 and R21's portable end empty. NA-E then it is nasal cannula tubing from nk, re-connected the tubing to liquid oxygen in R21's room, it is eliters on the standing oxygen E walked out of R21's room. It is each the time and asked NA-E than liters oxygen R 21 was to layer. NA-E showed surveyor the computer and R21's care is to be receiving oxygen at two id had set R21's oxygen at three ox into R21's room and in 22 liters on R21's standing in 8/13/14, at 11:17 a.m., R21 room in wheelchair and had a fit hand between thumb and first blor. R21's fingernails on nained long with black debris	F 2	82			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
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F 282	debris was underned bruise on top of left finger. NA-J had stare to be trimmed a bath days, should be when done, and who when done, and who when done, and who when done, and who was know. NA-J and a between the done on 8/14/14, at 3:14 and 6/20/14 care had been done on 8/14/14, at 3:14 and between thumb and RN-A measured the (centimeters) by 2.5 time R21 had a bruise color measuring 1.5 at the time R21 is 6/2014, 7/4/14, 7/1 and 8/12/14 had no problems or bruisin R21 is care plan problems or bruising and start problems. Problems or bruising, sk prominence. Problems or bruising sk prominence.	eath all fingernails and had a hand between thumb and first ated fingernails and toenails and cleaned underneath on be documented on bath sheets are a resident refuses to let verified at the time R21 's bath (12/14, and R21 's bath sheets (1/14, 7/25/14, 7/18/147/11/14, had no documentation nail e.  I. p.m., registered nurse (RN)-A bruise on top of left hand diffirst finger and at the time e bruise to be 2.5 cm form and in addition at the lise on the right hand middle in color measuring 1.2 cm by on right wrist dark purple in 5 cm by 1.3 cm. RN-A verified body audit forms dated 1/14, 7/18/14, 7/25/14, 7/30/14 of documentation of skin					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		245509	B. WING _		08/20	0/2014		
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F 282	weakness with intercheck fingernails end BM (bowel movement physical assist of oragrooming/hygiene, done after bath and for falling related to staff assistance to interventions of but reach.  R21 's resident proclinical monitoring skin daily with care clinical monitoring: via nasal cannula ain reach and behave check resident 's not be comment review of dated 6/20/14, 7/4/7/30/14 and 8/12/14 skin problems, bruisignature had been audit forms for the 7/11/14, 7/25/14 and nurse had complete	rventions of but not limited to ach shift with cares for dried ent) and clean/clip as needed, ne to two with weekly bath, nail care to be as needed. Problem: at risk impaired mobility, requires transfer to/from surfaces with not limited to keep call light in offile identified but not limited to skin dated 5/30/14, observe, report abnormal finding, administer oxygen at two liters is needed, falls: keep call light in oral symptoms: staff must	F 28	32				
	8/8/14.  Document review of 6/18/14, at 10:09 a. p.m., had no docum assessments being bruising. No docum record regarding th	of R21's progress notes dated .m., through 8/14/14, at 3:35 nentation of weekly skin g completed by a nurse or of nentation had been in R21's e three bruises R21 had until RN-A verify bruising on						

		(1) PROVIDER/SUPPLIER/CLIA (X2) N IDENTIFICATION NUMBER: A. BU		TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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F 282	in R21 's progress regarding the three During interview on of nursing (DON) h bruises, she would and reported and to bath after identified expect call light to be trimmed and cleans what orders are for should check profile setting oxygen is to time verified the sa During interview on administrator and readministrator had shath, and verified R completed for week Administrator verified had no nurse signa 7/11/14, 7/25/14 and verified bruises were body audit form dat stated R21 had a fabruises had not be fall report. Administratory dated 8/11/14 monitor for signs of a fall and provided history dated 8/11/14 monitor for signs of three days for three 8/12/14 through 8/1 staff had initialed the no bruises had beef four days. Administ have identified bruises have identif	note on 8/14/14, at 5:24 p.m., bruises.  8/14/14, at 4:03 p.m., director ad stated in regards to R21 's expect bruises to be identified o monitor bruises weekly with . DON had stated she would be in reach, fingernails to be ed weekly with bath, follow oxygen liters to be set at and e first if do not know what be on. Administrator at the	F 2	32			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245509	B. WING		08	/20/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 810 WEST MAIN STREET ADAMS, MN 55909	-		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE	
F 282	report to nurse, nuif cause unknown Health Facility Cordo incident report Administrator had audit form sheets she expected nurs sign the audit form bruises to be ident body audits. Admin plan read, "Licenweekly and docum" Administrator v body audit form ar read, "Observe s abnormal finding to bruising, skin tears prominence, etc." expected staff to fothe care plan had Document review ADMINISTRATION Oxygen administration of conduty and be resident and physician 's ordestaff person traine on duty and be residentially and be residentially and serious demands of the care plan had admission record on the conduction of the	ruise that they immediately urse completes incident report, then report to OHFC (Office of implaints) if cause is known then but do not report to OHFC. stated she would expect body to be completed for each bath, he to complete body audits and its and she expected the initiation of they exist " with the inistrator verified R21's care sed nurse to assess skin ment any findings on bath book. For they exist " with the inistrator verified R21's care plan kin daily with care report to nurse such as ulcers, is, redness over bony. Administrator had stated she collow the care plan and verified not been followed.  For the facility OXYGEN of the facility of the	F 2	282			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909	1 00		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 282	82 Continued From page 67		F 282	2			
	R12 had been sittir room doing exercis	on 8/13/14, at 11:21 a.m., ag in wheelchair in activity es, Geri sleeves had been on s/hands and bruising noted the					
	had been transferre and nursing assista bathroom, onto toile using a stand lift (n hands had been ob transfer). R12 had arms/hands and a	on 8/14/14, at 8:19 a.m., R12 ed by nursing assistant (NA)-K ant (NA)-L from bed into et, from toilet into wheelchair o bumping of R12 's arms or eserved by surveyor during Geri-sleeves on bilateral lower purple bruise had been visible mb and a purple bruise had mb on right hand.					
	verified R12 had a and a bruise by thu time RN-A measure hand by thumb to be color) and the bruis be 3 cm by 2 cm (pmember-C had beer removed R12's Gibilateral lower arms on bilateral hands a visible. RN-A at the right elbow a dark pcm, right below that measuring 2.5 cm lon top of right forea 4 cm and medium cm, right wrist dark top of right hand puand fifth finger 4.5 cm	p.m., registered nurse (RN)-A bruise on left hand by thumb mb on right hand and at the ed the bruise on top of left be 3 cm by 3 cm (dark purple in se on right hand by thumb to burple in color). R12' s family en present at the time and had eri sleeves from R12's shands and additional bruising and lower arms had been time measured the following: burple bruise 3.5 cm by 3.5 to two dark purple bruises by 1 cm and 1.5 cm by 1 cm, arm dark purple bruise 3 cm x red color bruise 1 cm by 2.5 purple 1.5 cm by 1.8 cm, on urple bruise between fourth cm by 1.5 cm, left hand under purple bruises measured 1.5					

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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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRINTED DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 282	cm by 1.2 cm and fading purple bruise forearm: purple bruise .75 cm by 2 cc cm, fading purple fading purple bruise side of left forearm 1.5 cm surrounded R12's care plan procategory skin identificated breakdown related fragile, receives bruthings while wheeling things or when become towards staff with a to: Geri sleeves bild careful when removed been skin daily wear report to nurse any inspections by a number of the weeks and 7/15/14, to verificate and round forms for the weeks and 7/15/14, to verificate and round forms for the weeks of 7/1/14, 8/4 at 3:40 p.m., RN-A documentation R12 8/4/14, printed from history, however the	2.75 cm x .5 cm, left wrist 2.1.5 cm by 2 cm, on left ise 1.5 cm by 1 cm, dark m by 1 cm, fading purple m, fading purple 3 cm by 5.75 l.5 cm by 1.5 cm, left wrist 2.1.5 cm by 2 cm and on outer a skin tear measuring 1 cm by by bruising 3 cm by 4 cm. roblem start date 5/27/2014, fied at risk for developing skin to but not limited to skin uses easily as bumps into ng self and/or reaching out for omes physically abusive pproaches of but not limited aterally except for cares, be ving Geri-sleeves and clothing, with cares in am and pm, issues and weekly skin rse.  If R12 's body audit forms 7/14, 6/24/14, 7/8/14, 7/125/14, 4 had no documentation of uising. No nurse signature ted on R12 's body audit of 6/10/14, 6/24/14, 7/8/14 fy a licensed nurse had ection of skin weekly and no ad been completed for R12 the 4/14 and 8/11/14. On 8/14/14, had provided surveyor 2 had received a bath on a the facilities point of care ere had been no sin assessment had been	F 28	82			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245509	B. WING _		08/	20/2014	
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909			
(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 APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 282	Document review of 6/10/14, at 12:04 p. p.m., had no documents being bruising other than right elbow old hem No documentation regarding the bruisafter surveyor had 8/14/14, at 3:14 p.m. in R12's progress regarding the bruisafter surveyor had 18/14/14, at 3:14 p.m. in R12's progress regarding the bruisafter surveyor had 18/14/14, at 3:14 p.m. in R12's progress regarding the bruisafter surveyor had 18/14/14, at 3:14 p.m. in R12's progress regarding the bruisafter surveyor had 18/14/14, at 3:14 p.m. in R12's progress regarding bruising on thing interview on the progress of the progress	ge 69  f R12 's progress notes dated m., through 8/12/14, at 1:40 hentation of weekly skin completed by a nurse or of on 7/21/14, at 10:23 a.m., atoma two cm diameter open. had been in R12 's record es as described above until RN-A verify bruising on h. RN-A had then documented note on 8/14/14, at 4:48 p.m., es as described above.  8/14/14, at 2:47 p.m., urse (LPN)-A had stated if ed after 7/28/14, would be book only. LPN-A verified R12 notes had no documentation on either of R12 's hands and ocumented in the orders of ing of bruising would be set  8/14/14, at 3:23 p.m., RN-A y audit forms dated 6/10/14, /8/14, 7/15/14, 7/22/14 and cumentation of skin problems  8/14/14, at 4:03 p.m., director ed in regards to R12 's expect bruises to be identified of monitor bruises weekly with a Administrator at the time	F 28	32			
	administrator and readministrator had v	8/20/14, at 9:15 a.m., with egistered nurse (RN)-D, erified no body audit forms d for R12 on 7/1/14, 8/4/14					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245509	B. WING			08/:	20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		8	STREET ADDRESS, CITY, STATE, ZIP CODE B10 WEST MAIN STREET ADAMS, MN 55909		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	and 8/11/14. Admin expected skin asse forms, were to be conurse reviewed the the body audit form verified there had be R12 's body audit form verified there had be R12 's body audit form says assessment as about the body audit form the weekly nurse skin concars any skin concars	istrator had stated she ssments were the body audit ompleted weekly and that the body audit forms and signed s weekly. Administrator had een no nurse signatures on orms dated 6/10/14, 6/24/14, Administrator had stated R12 ath, although verified lack of and lack of weekly skin ove. Administrator had stated s signed by the nurse were kin assessments. Stated she expected nursing ment am and pm in point of erns. Administrator had stated audit sheets to be completed expected a nurse to complete a a the body audit forms. Stated she expected the fied " if they exist " with the histrator had verified R12's observe skin daily with cares in a to nurse any issues " and " stated she expected staff to and verified the care plan had of the facility BODY AUDIT CEDURE dated 2007, read mpleted for all residents for rations in skin integrity. On resident bath/shower day, orm. 3. The Nursing Assistant ght, vital signs, indicates type nail care if appropriate. Then nt is to contact the Licensed	F2	282			

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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	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909		
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282 F 312 SS=D	Licensed Nurse cor inspection of the sk alterations in skin of form. The Licensed any pain concerns a Licensed Nurse and form. The Licensed policy if a change in and/or pain is noted Interdisciplinary Tea any changes in skin Update resident car assignment sheets During interview on regarding following requested from the been provided.  483.25(a)(3) ADL C DEPENDENT RES  A resident who is ur daily living receives maintain good nutrit and oral hygiene.	e skin inspection. 5. The impletes a head to toe in with notation of any condition on the Body Audit Nurse is also to assess for and note them. 6. The dinary Assistant signs the Nurse proceeds forward per in the resident 's skin condition if the tresident 's skin condition if the tresident is skin condition if the resident is skin condition in	F 282			9/17/14
	by: Based on observat review the facility fa	ion, interview and document iled to ensure clean and of 3 residents (R21) reviewed		R21's nails were cleaned and trime 08/13/2014 and will continue to be and trimmed. Nursing staff will ens nails are clean and trimmed for all residents of Adams Health Care Coon a daily basis.	clean ure that	
	R21 had been adm	itted on 4/11/14. R21 's		Nail care reviewed at a nursing		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	<u> </u>		E SURVEY PLETED
		245509	B. WING _			08/	20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, 810 WEST MAIN S ADAMS, MN 559		, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTI PRRECTIVE ACTION SHOUL FERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 312	quarterly Minimum 7/18/14, identified dementia, Parkinso chronic obstructive and required extense personal hygiene.  During observation had been in room stingernails on bilated black debris observation had been sitting in fingernails on bilated black debris observation nursing assistant (Not fingernails on bilated debris was underned stated fingernails and cleaned under documented on bated when a resident refiverified at the time 8/12/14, and R21 '7/30/14, 7/25/14, 7/6/20/14 had no documented on bated to check cares for dried BM clean/clip as needed	Data Set (MDS) dated but not limited to diagnoses of on's disease, heart failure, pulmonary disease (COPD) sive assist of one person for on 8/11/14, at 6:58 p.m., R21 sitting in wheelchair. R21's eral hands had been long with yed underneath all fingernails.  8/13/14, at 11:17 a.m., R21 room in wheelchair and R21's eral hands remained long with yed underneath all nails.  on 8/13/14, at 3:25 p.m., NA)-J verified R21's eral hands were long and black eath all fingernails. NA-J had not toenails are to be trimmed the sheets when done, and fuses to let nurse know. NA-J R21's bath day had been on s bath sheets dated 8/12/14, (/18/147/11/14, 7/4/14 and sumentation nail care had been on self-care deficit related to ess with interventions of but a fingernails each shift with (bowel movement) and ed, physical assist of one to two ene, weekly bath, nail care to	F 3	department r  Random aud bath day, per check for cle SD/IC and/or responsible t  Results will b forwarded to	meeting on 09/17/20° dits will be conducted riodically and as need an and trimmed nails their designee are to monitor for compliance for and continue to QA/QI Committee for ecommendation.	daily, on ded to s. DON, ance.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		245509	B. WING		08/:	20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909		
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From pa	ge 73	F 312	2		
F 323 SS=D	ADL (activities of da functional/rehabilita of one to two with g behavioral symptons nails daily.  Document review of dated 6/20/14, 7/4/7/30/14 and 8/12/14 care.  During interview on of nursing (DON) has fingernails to be trin bath. Administrator Policy for nail care I time, none had bee 483.25(h) FREE OF HAZARDS/SUPER.  The facility must enenvironment remain as is possible; and adequate supervision prevent accidents.  This REQUIREMENT by:  Based on interview facility failed to appell to perment and impell to the province of the provin	tion potential: physical assist rooming/hygiene and hs: staff must check resident '  f R21 's body audit forms 14, 7/11/14, 7/18/14, 7/25/14, 4 had no documentation of nail 8/14/14, at 4:03 p.m., director ad stated she would expect had stated she would expect had been requested at the n provided. F ACCIDENT VISION/DEVICES sure that the resident has as free of accident hazards each resident receives on and assistance devices to had document review, the ropriately assess the risk for lement interventions to and safety for 1 of 1 resident	F 323	R43 has not made any attempts to the facility grounds since the respo party (sister) has requested that R4 allowed to go outside independently 08/29/2014. R43 is no longer consi	nsible 13 be y on	9/17/14

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		(X3) DATE COMF	SURVEY
		245509	B. WING _			08/2	20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY 810 WEST MAIN STRE ADAMS, MN 55909	EET	33.	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD ENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Findings Include:  R43's admission rediagnoses of bipola obsessive compuls history of traumatic change Minimum Dindicated R43 had status (BIMS) score impairment.  Review of incident eloped from the fact 4/10/14 and 6/3/14.  Resident Incident R43 had an unwith p.m., "Resident wa [R43] pushed the diffront door of the fact with resident down returned to the fact the parking lot." Imfurther injury to resident manitoring. Prior Minimum was orientated to pingo outside with resident proceeded to go outside with resident pusproceeded to go outside in the proceeded on the status: indicated R4 to assist outside if pingo outside in pingo outside if pingo outside in pingo outside if pingo outside in pingo outside in pingo outside if pingo outside in pingo	cord identified R43 had ar disorder, schizophrenia, ive personality disorder, and brain injury. R43's significant that Set (MDS) dated 5/7/14 a brief interview for mental e of 14 indicating no cognitive reports revealed R43 had sility on 4/1/14, 4/7/14, 4/8/14,	F 32	an elopement risconcurs with this continue to mon provide safety a residents of Ada will be assessed admission and a interventions will provide supervise Elopement risk a reviewed at an A 09/17/2014.  Random audits admission and p Social Services designee are recompliance.	Il be implemented to sion and safety.  assessment policy All Staff meeting on will be conducted at periodically as need Director, DON and/sponsible to monito forwarded to QA/QI eview and further	outs to enter at o	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		8	TREET ADDRESS, CITY, STATE, ZIP CODE  10 WEST MAIN STREET  DAMS, MN 55909	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	staff was alerted to R43 was outside, o into the facility.  Resident Incident R43 had an unwitne p.m., "staff reporte w/c [wheelchair] or end of the side wall Immediate action to resident: indicated Prior Mental status: Plan: remind reside outside. On 8/13/14 the incident report of alerted to R43 being outside, or how R43 facility.  Resident Incident R43 had an unwitne p.m., "staff noted resident	ge 75 It report did not include, how R43 being outside, how long re how R43 was brought back Report dated 4/8/14 indicated essed elopement. At 4:50 desident was outside without walker. Had made it to the keep from the front entrance." In prevent further injury to removed to place of safety." It indicated R43 was forgetful. ent to ask staff before going at 12:16 p.m. LSW-A verified did not include, how staff was goutside, how long R43 was goutside, h	F3	323			
	walked out by hims parking lot." Imme injury to resident: in safety. Prior Menta forgetful. Plan: "remoutside or have sta [Interdisciplinary teasafety/elopement, flike to see more incoutside independer when decision is m  Resident Incident Rindicated R43 had a	elf and had made it to the ediate action to prevent further edicated removed to place of all status: indicated R43 was nind resident to ask to go ff go outside with resident. IDT am] to meet [with] concerns for amily member (FM)-A would dependence [with] going ntly. Will update care plan					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		ATE SURVEY OMPLETED
		245509	B. WING		0	8/20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909		
(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 SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	[feet] away from the sounding. Res [resi circle the block and Immediate action to resident: indicated estatus: indicated R4 forgetful and confus [R43] that [R43] need he goes outside."  R43's care plan datan, "elopement risk	ide. Found res [resident] 50 ft. e main entrance, alarm dent] said, 'I just wanted to	F 3	23		
	ask staff to accomp button as observed however other time alarmed." The care that R43 "will ask st each time through t plan listed intervent added to facility Wa whereabouts, remir assistance when wi aware of resident's and is near front en walker and assistar times in/outside.	pany him. Is aware to push pushing the front door button is have went out and doors a plan further identified a goal taff to accompany him outside the next review." The care ions including: Resident andering Book. Staff to monitor and resident to ask for shes to go outside, staff to be location when up ambulating trance. Educate need for the ince when ambulating at all are plan dated 5/8/14,				
	identified R43 was, person, place and t known. Some short impairments preser becomes confused care plan further identified maintain current codecline through new interventions including person.	"alert and oriented x 3 [to ime]. Able to make needs and long term memory at. He is forgetful and d/t [due to] brain injury. The entified a goal that R43 "will gnitive abilities and show no treview." The care plan listed ing: Allow resident to make ons as often as possible.				

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 810 WEST MAIN STREET ADAMS, MN 55909		
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	process what is be often come up with R43 is not rushed. Check for understa questions. Point or assist resident with On 8/13/14 at 12:1 a traumatic brain it was not going to re to go outside. LSW reminding R43 to aput into place to presidents' repeate effective due to R4 On 8/14/14 at 9:34 facility does not co assessments for releaves the building considered a risk for the wandering boomeetings and detego outside on their "based on staffs' of can be outside unaher opinion on the LSW-A stated she the period of elope wandering book ha R43. LSW-A verification on the LSW-A stated she the period of elope wandering book ha R43. LSW-A verification on 8/14/14 at 10:00 (DON), stated, "An completed on each The DON verified states and the states of the states	Give resident plenty of time to ing said or asked. R43 can an answer on R43's own if Offer reminders as needed. anding by using 'yes' or 'no' ut clocks and calendars to orientation to time/dates.  6 p.m. LSW-A stated R43 had anjury (TBI), poor memory and emember to ask for assistance of the intervention of ask staff to go outside that was event reoccurrence of delopements would not be 3's TBI and poor memory.	F 3:	23		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 323	medical record and assessment had be DON stated staff sl elopement assess every resident and be made to determ elopement had chastay. The DON verishould have been trisk for elopement.  An Elopement Risk follows:  Definition of Eloper Any resident attem without the assistant determined as atterned as atterned as atterned as atterned to the rights and facility maintains a prevention strategie elopement risk, insidentification to be the time of admission resident procedure.  1. All entrances to system in place.  2. Staff will be educted redirection of residented.	I stated an elopement een added on 8/14/14. The nould be completing an ment upon each admission for verified reassessments should ine if residents risk for anged during the course of their fied the wandering book updated to reflect R43 was at a policy dated 3/2011 read as a policy dated 3/2011 read as ment pting to exit the building ance of family will be mpted elopement.  To promote resident safety and and dignity of the residents. The process to implement es for those identified as an titute measures for resident used in the Wandering book at on, and conduct a missing	F 32	3		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245509	B. WING		08/2	20/2014
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909		
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	an elopement risk v to the facility wander 5. Residents at risk elopement care plated. 6. Staff will complete plan in the event that the facility and cannot 7. Recurring elopement in place.  Although R43 had et 4/8/14, 4/10/14 and comprehensively as elopement risk to diappropriate interver	ave been identified as being will have their profile added wring book.  for elopement will have an in place e a missing resident action at a resident has eloped from	F 323			
F 332 SS=D	RATES OF 5% OR  The facility must en	OF MEDICATION ERROR MORE  sure that it is free of the set of the s	F 332	2		9/17/14
	by: Based on observat review the facility fa	NT is not met as evidenced ion, interview and document iled to ensure a medication an 5% for 2 of 7 residents (R3, ng the medication		All medications will be administered physician's orders and per Adams For Care Center Medication Procedure.	Health	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245509	B. WING			08/2	20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET DAMS, MN 55909		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 332	administration obsermedication error rates Findings include:  R3 was observed dadministration on 8 observation of gast administration. Durnurse (RN)-C took them all together in medications were la (milliliter) (a synthetic constipation), meto (milligrams) (a heard 10 mg (a cholesterd were all crushed and medication and 120 water. After mixing water and checking attached the syring medications. R3's gobeen flushed with the fore and after medications were nonce. RN-C verified water is just given wafter medications, whours 60 cc before do it the unconvent going to tell me I did other than every for feeding and meds,  Document review of 6/24/14, identified of the convent in th	uring medication //11/14, at 5:35 p.m. ric tube (GT) medication ing preparation, registered each medication and mixed a drinking cup. The actulose solution 5 ml tic sugar used to treat prolol tartrate 12.5 mg rt medication) and simvastatin ol lowering drug). The tablets ad placed in with the liquid occ (cubic centimeters) of all medications together with a placement of the GT RN-C et to the GT and pushed in the gastrostomy tube (GT) had not ne prescribed amount of water edication administration and all nixed together and given at d at the time and had stated, "with the pills, not before and we flush with water every four and after feeding and meds, I ional way, you are probably d it wrong, no other flushes ur hours before and after none between meds. "	F3	32	Medication Procedure and Feeding Policy reviewed at a Nursing Department on 09/17/2014 to ensure the medications are accurately administrated and once per offer one month and once per month months to monitor for compliance. SD and/or their designee are respect to monitor for compliance.  Results will be forwarded to QA/QI Committee for review and further recommendation.	rtment hat stered. week for 3 DON,	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245509	B. WING _		08	/20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 332	Document review of administration histor 8/13/14, identified if flush J-tube with 60 feeding and meds,  During interview on of nursing had state be done before and administered as ord  Document review of POLICY AND PRO "OTHER MEMBER INTERDISCIPLINA AFTER Meds per Medications for R6 vitamin D3 1,000 un (which contained R and then LPN-E had medications to R61 Document review of dated 6/18/14, iden 1,000 unit two tables by mouth or During interview on During interview on administration history and the service of t	of R3's medication ory dated 8/1/14 through clush check every four hours, occ of water before and after six times per day.  8/13/14, at 3:04 p.m., director ed would expect water flush to dafter medications dered.  If the facility FEEDING TUBE CEDURE dated 6/5/10, read S OF THE RY Flush tube BEFORE and MD order"  during medication /14/14, at 7:53 a.m., licensed N)-E was observed to prepare 1 and had placed one tab of init into a medication cup 61's other oral medications) d administered the  If R61's physician orders tified order for vitamin D3 its by mouth one time daily.  If R61's medication ory dated 8/1/14 through vitamin D3 1,000 unit two	F 3:	32		
	read vitamin D3 1,0	000 unit two tablets by mouth l-E verified had given R61 one				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	LE CONSTRUCTION		E SURVEY IPLETED
		245509	B. WING		08/	20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER	8	STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909		
(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 APPROPORTION OF T	BE	(X5) COMPLETION DATE
F 332 F 431 SS=D	tablet of Vitamin D3 administration and During interview on of nursing had state order before giving dose had been give Document review of Care Center Medica 5/10/10, read " 4. Emedication, the resist checking the MAR are accurate ad 483.60(b), (d), (e) ELABEL/STORE DR The facility must en a licensed pharmac of records of receip controlled drugs in accurate reconciliat records are in order controlled drugs in reconciled.  Drugs and biological abeled in accordant professional princip appropriate accessinstructions, and the applicable.  In accordance with facility must store a locked compartment.	at time of medication not two tablets as ordered.  8/14/14, at 3:49 p.m., director ed would expect too look at vitamin D3 to assure correct en.  If the facility Adams Health ation Procedure dated revised Before administering ident must be identified, and the card or bottle to ministration. "DRUG RECORDS, UGS & BIOLOGICALS apploy or obtain the services of cist who establishes a system t and disposition of all sufficient detail to enable an ion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be not expected les, and include the ory and cautionary experience and biologicals in ats under proper temperature to only authorized personnel to	F 332			9/17/14

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE COMF	SURVEY PLETED
		245509	B. WING		08/2	20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER	8	STREET ADDRESS, CITY, STATE, ZIP CODE 110 WEST MAIN STREET ADAMS, MN 55909	33.2	
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	permanently affixed controlled drugs list Comprehensive Dr Control Act of 1976 abuse, except whe package drug distriquantity stored is mbe readily detected.  This REQUIREMED by: Based on observated documentation reviaccurate medication labels reviewed for observed during maproperly date eye dfor 1 of 2 eye drops medication storage expired eye drop mfor R22 reviewed detected.  ACCURATE MEDICAL R61's Ativan medicalistics abuse include:	ovide separately locked, discompartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the hinimal and a missing dose can developed.  It is not met as evidenced to the facility failed to ensure in labels for 2 of 15 medication 1 of 7 residents (R61) dedication pass; failed to rop medication when opened a for R22 reviewed during task; and failed to discard an edication for 1 of 2 eye drops uring medication storage task.  CATION LABELS:	F 431	All medications will be accurately la all eye drops will be properly dated opened and all expired eye drops a discarded.  Medication Procedure regarding la and Eye Drop Protocol were review nursing department meeting on 09/17/2014.  Audits will be conducted once per v for a month and once per month for months to monitor for compliance. SD and/or designee are responsible monitor for compliance.	when re beling red at a week r 3 DON,	
	at 7:53 a.m., R61 'had read 0.5 mg (nneeded and cetirizi and the labels had However R61 's phread Ativan 1 mg, 0	stration observation on 8/14/14, is medication labels for Ativan illigrams) BID (twice daily) as the had read 10 mg at bedtime no indication of order change. The hysician orders dated 6/18/14, 10.5 mg to 1 mg three times are by mouth at bedtime and		Results are forwarded to QA/QI Committee for review and further recommendation.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION  IG	` ´com	
		245509	B. WING _		08/	/20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 431	afternoon and cetiric Licensed practical in time of medication labels for Ativan and the physician order. The physician order medication labels how of change in order.  During interview on of nursing had state labels not correct, in pharmacy new order new med or new lad on the labels to ided double check order label comes from public	simes a day in the morning and zine 10 mg once a morning. The nurse (LPN)-E verified at the administration observation the discription desired and the administration observation the discription and the administration of the labels.  8/14/14, at 3:49 p.m., director and in regards to medication at its the facility policy to fax the ers and the pharmacy sends only there are stickers to put nutify order change to alert to until the new medication or harmacy.  If the facility Adams Health action Procedure dated revised Medications with a changed of the relabeled by a licensed.  WHEN OPENED & DEYE DROPS:  Redication were found during on storage on 8/14/14 at 2:33 prost found in the small expiration date written in of the distribution of the practical nurse (LPN)-B was receiving the eye drop are been destroyed. It was not seen and that the bottle was not	F 43			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION  NG	` '	E SURVEY IPLETED
		245509	B. WING _		08/	20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 431	on 6/23/14. The ph 7/22/14 indicated th ophthalmic drops, 0 and latanoprost oph eyes once a day at The Medication Adraugust 2014 indica receiving the undat expired latanoprost During an interview 8/14/14 at 3:46 p.m that if the eye drops or if eye drops were used and thrown out During a telephone a.m. the facility 's of that it would be his had written in expire been destroyed and	cated that R22 was admitted aysician order sheet signed on lat R22 was to receive timolol 0.5% in both eyes once a day athalmic drops 0.005% in both bedtime.  Ininistration Record (MAR) for ted that R22 had been led timolol eye drops and the eye drops.  With the administrator on lateral than the eye drops.  With the administrator on lateral than the experiment of the lateral than the experiment of the lateral than the expectation if the lateral than the expectation of the expectation of the lateral than the expectation of the expe	F 43	31		
F 441 SS=F	An undated policy t that all eye drop co it was opened on it. away after 30 days container, eye drop 483.65 INFECTION SPREAD, LINENS  The facility must es Infection Control Pr	pened and should have been ould be his expectation.  Itled Eye Drop Protocol read nationers need to have the date Eye drops will be thrown If there is no date on s will be destroyed.  I CONTROL, PREVENT  Itablish and maintain an ogram designed to provide a comfortable environment and	F 44	11		9/17/14

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED
		245509	B. WING _		08/20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909	, , , , , , , , , , , , , , , , , , , ,
(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  CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE COMPLETION
F 441	of disease and infe  (a) Infection Contro The facility must es Program under whi (1) Investigates, co in the facility; (2) Decides what p should be applied t (3) Maintains a rec- actions related to in  (b) Preventing Spre (1) When the Infect determines that a r prevent the spread isolate the resident (2) The facility must communicable dise from direct contact direct contact will tr (3) The facility must hands after each d hand washing is ind professional practic  (c) Linens Personnel must ha	development and transmission action.  Of Program Stablish an Infection Control ich it - antrols, and prevents infections rocedures, such as isolation, or an individual resident; and ord of incidents and corrective infections.  Dead of Infection to Control Program esident needs isolation to of infection, the facility must in the prohibit employees with a ease or infected skin lesions with residents or their food, if transmit the disease. It require staff to wash their irect resident contact for which dicated by accepted	F 44	1	
	by: Based on observa review, the facility	NT is not met as evidenced tion, interview and document failed to implement ent the possible spread of		All residents of Adams Health Car Center who have an order for bloo checks have their own glucometer	d sugar

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	` /	E SURVEY PLETED
		245509	B. WING			08/:	20/2014
ADAMS	PROVIDER OR SUPPLIER HEALTH CARE CENT			8	TREET ADDRESS, CITY, STATE, ZIP CODE  10 WEST MAIN STREET  ADAMS, MN 55909		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	observations for 1 oblood sugars taken program lacked dood determine infection residents and staff. affect all 45 residen	od glucose monitoring of 1 residents (R25) who had and the infection control cumentation of the analysis to cross-contamination between This had the potential to its, staff, and visitors.  MONITOR LACKED REVENT THE SPREAD OF THER RESIDENTS WHO	F4	41	machines and such glucometer may will be cleaned after each use. An infection surveillance analysis and trending will be completed for staff determine cross-contamination bet residents and staff.  The Glucometer Cleaning Policy at Calling-in Policy were reviewed at a Nursing Department meeting held 09/17/2014.  Audits will be conducted once per for a month and once per month for months to monitor for compliance. SD/IC and/or their designee are responsible to monitor for compliar Results will be forwarded to QA/QI Committee for review and for further recommendation.	to tween and the a on week or 3 DON,	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING		(X3) DATE SURVE COMPLETED	
		245509	B. WING		_	08/	20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, S' 810 WEST MAIN STREET ADAMS, MN 55909		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION IVE ACTION SHOULD ED TO THE APPROPI FICIENCY)	BE	(X5) COMPLETION DATE
F 441	for R25 's insulin a picked up the glucohallway to the mediplaced the glucome LPN-C had not laid tray table and glucothe tray table and glucothe tray table after had had not sanitized and had placed the cart, inside a drawer plastic container and handling the un-sarverified the above at Document review of dated 7/7/14, identified the above at Document review of nursing stated stray table at have been cleaned and putting back in Document review of GLUCOMETER CL read "POLICY: To glucometer maching infection control. Plagucometer with a prodisinfect the maching for 2 minutes after submerse in water sanitizing wipe. Thi Place glucometer in	dministration and then had breter and walked down the cation storage room and had ater in a plastic container. barrier between surface of ometer and had not sanitized removal of glucometer. LPN-C and the glucometer after use glucometer on top of the med and had not worn gloves when notized glucometer. LPN-C at the time.  If R25 's physician orders fied order check blood sugars and bedtime.  8/13/14, at 3:04 p.m., director and tray table or should of and the glucometer should before placing on med cart to plastic container.  If Adams Health Care Center LEANING POLICY undated, ensure proper cleaning of the between each use for good ROCEDURE: 1. Wipe the purple top wipe container to the container to the container with the designated slot in tote this process must be done after the container of the designated slot in tote this process must be done after the container of the designated slot in tote this process must be done after the container of the designated slot in tote this process must be done after the container of the designated slot in tote this process must be done after the container of the designated slot in tote this process must be done after the container of the designated slot in tote the process must be done after the container of the designated slot in tote the container of the		41			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		245509	B. WING		08	/20/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, 2 810 WEST MAIN STREET ADAMS, MN 55909		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 441	DETERMINE INFE CONTAMINATION AND STAFF:  The facility was unathey had tracked arand infections to debetween the reside  During an interview licensed practical nwas no documentate employee illness ar infection cross confresidents and staff and absence. She sanalysis when she illness, but stated sanalysis as she had The policy entitled I Health dated 2008 address tracking, tremployee illness ar	A OF THE ANALYSIS TO CTION CROSS BETWEEN THE RESIDENTS  able to provide documentation and trended employee illness etermine cross contamination and staff.  Ton 8/14/14 at 6:07 p.m., urse (LPN)-A verified there tion to show analysis of the and infections to determine tamination between the has occurred for staff illness stated she completed the tracked and trended employee the did not document the did the information in her head. Infection Control Employee was reviewed and did not tending and analysis of and infections to determine tamination between the	F 4			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245509	B, WING	_		08	/13/2014
	PROVIDER OR SUPPLIER	ER		81	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET DAMS, MN 55909	*	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 000	INITIAL COMMEN	гѕ	K	000			
	FIRE SAFETY						
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE CATION OF COMPLIANCE.					
	ONSITE REVISIT OF CONDUCTED TO SUBSTANTIAL COREGULATIONS HA	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	Minnesota Departm Fire Marshal Division Adams Health Care substantial complian participation in Med Subpart 483.70(a), 2000 edition of Nat Association (NFPA)	Survey was conducted by the nent of Public Safety - State on. At the time of this survey, e Center was found not in ince with the requirements for dicare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection Standard 101, Life Safety er 19 Existing Health Care.					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO:	R THE FIRE SAFETY			<b>EPOC</b>		
	State Fire Marshal 445 Minnesota St., St Paul, MN 55101	Division Suite 145					
BORATOR	OIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

**Electronically Signed** 

09/11/2014

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

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED  08/13/2014	
		245509	B. WING				
	PROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE 110 WEST MAIN STREET ADAMS, MN 55909		
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	By email to: Marian THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO  1. A description of to correct the defic  2. The actual, or po  3. The name and/of	PRRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. roposed, completion date. or title of the person	КС	000			
	The Adams Health building with no ba constructed at 2 di building was const to be of Type II(111 addition was const Type II (111) constructed at 2 di building was const to be of Type II (111) constructed at 2 di building was const to be of Type II (111) constructed at 2 di building was constructe	rection and monitoring to ence of the deficiency.  Care Center is a 1-story sement. The building was fferent times. The original ructed in 1976 and determined 1) construction. In 1992, an ructed and determined to be of ruction  sprinklered. The facility has a					
	fire alarm system with the corridors and so is monitored for au notification.	vith partial smoke detection in paces open to the corridor that tomatic fire department			1500 S+ 12		
	census of 42 beds	apacity of 49 beds and had a at the time of the survey.			S ").		
K 011 SS=D	NOT MET as evide	t 42 CFR, Subpart 483.70(a) is enced by: AFETY CODE STANDARD	K	011			9/10/14

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l , ,		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245509	B. WING			08/	13/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET DAMS, MN 55909		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 011	If the building has a nonconforming bui barrier having at le rating constructed addition. Commun corridors and are p	age 2 a common wall with a lding, the common wall is a fire ast a two-hour fire resistance of materials as required for the licating openings occur only in protected by approved ors. 19.1.1.4.1, 19.1.1.4.2	К	D11			
	Based on observa facility failed to pro at building separati 2000 - NFPA 101, s	is not met as evidenced by: tion and staff interview, the vide 2-hour rated construction ion wall in accordance with sections 19.1.1.4.1. The ould affect all 12 out 42	-		The open penetrations in the 2-howall above the ceiling at the west wand 2hour fire separation wall from Center to Assisted Living were fire caulked around ends of conduits.  All 2 hour fire separation walls were checked.	ing Care	
	on 08/13/2014, obsopen penetrations the ceiling at the wall from Care Cer	ween 8:30 AM and 11:30 AM servation revealed, there are in the 2-hour rated wall above est wing, 2 hour fire separation around and ends of conduits					
K 038 SS=D	This deficient pract facility maintenance discovery. NFPA 101 LIFE SA	2 hour fire separation walls tice was confirmed by the e staff (DE) at the time of AFETY CODE STANDARD nged so that exits are readily nes in accordance with section	K	038			9/17/14

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	RS FOR MEDICARI	G MEDIO/ ND OLIVIOLO			ONB NO.	
TATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	PLE CONSTRUCTION IG <b>01 - MAIN BUILDING 01</b>		E SURVEY PLETED
		245509	B. WING_		08/	13/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909	·	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
K 038	Continued From pa	age 3	K 03	38		
	Based on observa provide means of of following requirem	is not met as evidenced by: ation, the facility failed to egress in accordance with the ents of 2000 NFPA 101, 7.1.6. The deficient practice out 42 residents.		Southland construction compan the hard path to the public way a replace the uneven hard path ce 09/17/2014. The hard path will b cement.	nd ment on	E-
	on 08/13/2014, obs	ween 8:30 AM and 11:30 AM servation revealed, that the g exit, the following items were				
		not go to the public way s there is uneven and has elevation change				
K 046	facility maintenance discovery.	actices were confirmed by the e staff (DE) at the time of	K 04	46		9/11/14

Event ID: 5UEX21

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245509	B. WING			08/	13/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET DAMS, MN 55909		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 046	Continued From pa emergency lighting 101, Section 192. practice could affect	as required by 2000 NFPA 9.1, and 7.9.2. The deficient	K	046	09/11/2014 by Schmitz Electric.		
K 062	on 08/13/2014, obstattery operated er emergency generatested.  This deficient pract facility maintenance discovery.	veen 8:30 AM and 11:30 AM servation revealed that the mergency lighting in the tor room did not work when lice was confirmed by the e staff (DE) at the time of	K	062			8/19/14
SS=D	continuously mainta condition and are in	c sprinkler systems are ained in reliable operating aspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25,					
	Based on observariacility failed to mai in accordance with NFPA 101, Sections 1998 NFPA 25, sec	s not met as evidenced by: tion and staff interview, the ntain the fire sprinkler system the requirements of 2000 s 19.3.5 and 9.7, as well as tion 2-2.1.1 and 2-4.1.4. This ould affect all 12 out of 42			The sprinkler heads in the kitchen of washing area were replaced with Te sprinkler heads and the spare sprinhead box now contains 2 of each sprinkler heads. This was done by Olympic Fire on 08/19/2014.	eflon kler	
	Findings include:						

	TO TOTT MILDIOT II TE	& MEDICAID SERVICES				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245509	B. WING		08/	13/2014
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CO 810 WEST MAIN STREET ADAMS, MN 55909	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 062	on 08/13/2014, obs following was found 1. The kitchen dish heads are corroded annual fire sprinkle 6/17/14 and 6/13/1 2. Spare sprinkler (2) spare sprinkler (2) spare sprinkler These deficient prafacility maintenance discovery. NFPA 101 LIFE SA Electrical wiring an with NFPA 70, Nat This STANDARD is Based on observate facility failed to mai accordance with the 101 - 19.5.1, 9.1.2, deficient practice or residents.  Findings include:  On facility tour between the state of the state o	veen 8:30 AM and 11:30 AM servation revealed that the di:  n washing area - sprinkler d . This was also noted on the r reports from Olympic dated	K 00	52	13/2014 and Please do the circuit	8/15/14

NAME OF PROVIDER OR SUPPLIER ADAMS HEALTH CARE CENTER    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY)   ID PREFIX TAG	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01			COMPLETED	
NAME OF PROVIDER OR SUPPLIER  ADAMS HEALTH CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  K 147  Continued From page 6 2. Generator room 3. North wing housekeeping closet  NOTE: Check the entire facility for this deficiency This deficient practice was confirmed by the facility maintenance staff (DE) at the time of discovery.  *TEAM COMPOSITION*  SUMMARY STATEMENT OF DEFICIENCIES B10 WEST MAIN STREET ADAMS, MN 55909  PREFIX TADRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909  FROVIDER'S PLAN OF CORRECTION (XS) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  K 147  Continued From page 6 2. Generator room 3. North wing housekeeping closet  NOTE: Check the entire facility for this deficiency This deficient practice was confirmed by the facility maintenance staff (DE) at the time of discovery.  *TEAM COMPOSITION*		245509		B. WING		08/13/2014		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  K 147  Continued From page 6 2. Generator room 3. North wing housekeeping closet  NOTE: Check the entire facility for this deficiency This deficient practice was confirmed by the facility maintenance staff (DE) at the time of discovery.  *TEAM COMPOSITION*					810 WEST MAIN STREET			
2. Generator room 3. North wing housekeeping closet  NOTE: Check the entire facility for this deficiency  This deficient practice was confirmed by the facility maintenance staff (DE) at the time of discovery.  *TEAM COMPOSITION*	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI	PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPRO		BE	COMPLETION
	K 147	2. Generator room 3. North wing hous  NOTE: Check the e  This deficient practifacility maintenance discovery.  *TEAM COMPOSIT	sekeeping closet entire facility for this deficiency lice was confirmed by the e staff (DE) at the time of	K1	147			