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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 89GV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00255

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245289**
2.STATE VENDOR OR MEDICAID NO.
(L2) **604140000**

3. NAME AND ADDRESS OF FACILITY
(L3) **CRYSTAL CARE CENTER**
(L4) **3245 VERA CRUZ AVENUE NORTH**
(L5) **CRYSTAL, MN** (L6) **55422**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/20/2013**

6. DATE OF SURVEY **03/17/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **130** (L18)

13.Total Certified Beds **130** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A,5** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	130			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Shawn Soucek, HPR SWS 06/01/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/02/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1984
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00325
(L31)

30. REMARKS
Posted 06/08/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/24/2015
(L33)

DETERMINATION APPROVAL

CCN: 24 5289

On March 17, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR), which included investigation of complaint number H5289044, that was determined to be unsubstantiated. In addition, on February 12, 2015 and May 28, 2015, the Minnesota Department of Public Safety completed a LSC PCR and an FMS PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 9, 2015 and an Federal Monitoring Survey (FMS) completed on February 25, 2015. We presumed, based on your plan of correction, that the facility had corrected these deficiencies as of April 8, 2015. Based on our PCR, we have determined that the facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 9, 2015 and the FMS completed on February 25, 2015, effective April 8, 2015.

As a result of the revisit findings, this Department recommended to the CMS Region V Office the following action related to the remedy outlined in their letter of March 11, 2015. The CMS Region V Office concurs and has authorized this Department to notify the facility of following action:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective April 9, 2015 be rescinded. (42 CFR 488.417(b)).

Correction of the Life Safety Code deficiencies cited under K12 at the time of the February 25, 2015 FMS survey, have not yet been verified. The facility's plan of correction for these deficiencies, including their request for a temporary waiver with a date of completion of August 24, 2015, has been approved. The facility's request for a continuing waiver involving the deficiency cited under K67 at the time of the February 12, 2015 LSC survey has been forwarded to CMS for their review and determination. Approval has been recommended based on submitted documentation.

In accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), the facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 9, 2015, due to denial of payment for new admissions. Since the facility attained substantial compliance, the original trigger remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Refer to the CMS 2567b forms for health, LSC and FMS for the results of this visit.

Effective April 8, 2015, the facility is certified for 130 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245289

June 2, 2015

Ms. Annette Thorson, Administrator
Crystal Care Center
3245 Vera Cruz Avenue North
Crystal, Minnesota 55422

Dear Ms. Thorson:

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 April 8, 2015 the above facility is certified for:

130 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 130 skilled nursing facility beds.

Your request for a temporary waiver of K12 with a date of completion of August 24, 2015 has been approved based on the submitted documentation.

We have recommended CMS approve the waiver that you requested for the following Life Safety Code Requirement K67.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiencies or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 1, 2015

Ms. Annette Thorson, Administrator
Crystal Care Center
3245 Vera Cruz Avenue North
Crystal, MN 55422

RE: Project Number S5289026, F5289025, H5289044

Dear Ms. Thorson:

On January 28, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 9, 2015. 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 February 25, 2015, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS), completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies at the time of the FMS were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), where corrections were required. On March 11, 2015, CMS forwarded the results of the FMS and notified you that your facility was not in substantial compliance with the Federal requirements for nursing homes participation in the Medicare and Medicaid programs and that they were imposing the following enforcement remedy:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective April 9, 2015 (42 CFR 488.417(b)).

Also, the CMS Region V Office notified you in their letter of March 11, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 9, 2015.

On March 18, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) which included investigation of complaint number H5289044, which was determined to be unsubstantiated. In addition, on February 12, 2015 and May 28, 2015, the Minnesota Department of

Public Safety completed a LSC PCR and an FMS PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 9, 2015 and the FMS completed on February 25, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 8, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 9, 2015 and the FMS completed on February 25, 2015, effective April 8, 2015.

As a result of the revisit findings, this Department recommended to the CMS Region V Office the following action related to the remedy outlined in their letter of March 11, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of following action:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective April 9, 2015 be rescinded. (42 CFR 488.417(b)).

Your request for a continuing waiver involving the deficiency cited under K67 at the time of the January 9, 2015 standard survey has been forwarded to CMS for their review and determination. Approval of the waiver has been recommended.

Correction of the Life Safety Code deficiency cited under K12 at the time of the February 25, 2015 Federal Monitoring Survey, has not yet been verified. Your plan of correction for this deficiency, including your request for a temporary waiver with a date of completion of August 24, 2015, has been approved.

However, as CMS notified you in their letter of March 11, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 9, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on April 8, 2015, the original trigger remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

Sincerely,

Mark Meath

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245289	A. Building B. Wing **01 - MAIN BUILDING 01**	5/28/2015

Name of Facility	Street Address, City, State, Zip Code
CRYSTAL CARE CENTER	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

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	Correction Completed **03/11/2015**	ID Prefix	Correction Completed **04/08/2015**	ID Prefix	Correction Completed **04/01/2015**
Reg. # **NFPA 101** LSC K0014		Reg. # **NFPA 101** LSC K0015		Reg. # **NFPA 101** LSC K0017	
ID Prefix	Correction Completed **04/01/2015**	ID Prefix	Correction Completed **04/01/2015**	ID Prefix	Correction Completed **04/01/2015**
Reg. # **NFPA 101** LSC K0018		Reg. # **NFPA 101** LSC K0020		Reg. # **NFPA 101** LSC K0025	
ID Prefix	Correction Completed **04/01/2015**	ID Prefix	Correction Completed **04/01/2015**	ID Prefix	Correction Completed **04/01/2015**
Reg. # **NFPA 101** LSC K0027		Reg. # **NFPA 101** LSC K0029		Reg. # **NFPA 101** LSC K0033	
ID Prefix	Correction Completed **04/01/2015**	ID Prefix	Correction Completed **04/01/2015**	ID Prefix	Correction Completed **04/01/2015**
Reg. # **NFPA 101** LSC K0038		Reg. # **NFPA 101** LSC K0046		Reg. # **NFPA 101** LSC K0048	
ID Prefix	Correction Completed **04/01/2015**	ID Prefix	Correction Completed **04/01/2015**	ID Prefix	Correction Completed **04/01/2015**
Reg. # **NFPA 101** LSC K0050		Reg. # **NFPA 101** LSC K0051		Reg. # **NFPA 101** LSC K0052	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/mm	06/01/2015	28120	05/28/2015
Reviewed By **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245289	A. Building B. Wing **01 - MAIN BUILDING 01**	5/28/2015

Name of Facility	Street Address, City, State, Zip Code
CRYSTAL CARE CENTER	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

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	Correction Completed **04/01/2015**	ID Prefix	Correction Completed **03/18/2015**	ID Prefix	Correction Completed **04/01/2015**
Reg. # **NFPA 101** LSC K0054		Reg. # **NFPA 101** LSC K0056		Reg. # **NFPA 101** LSC K0062	
ID Prefix	Correction Completed **04/01/2015**	ID Prefix	Correction Completed **04/01/2015**	ID Prefix	Correction Completed **04/01/2015**
Reg. # **NFPA 101** LSC K0064		Reg. # **NFPA 101** LSC K0066		Reg. # **NFPA 101** LSC K0067	
ID Prefix	Correction Completed **04/01/2015**	ID Prefix	Correction Completed **04/01/2015**	ID Prefix	Correction Completed **04/01/2015**
Reg. # **NFPA 101** LSC K0069		Reg. # **NFPA 101** LSC K0072		Reg. # **NFPA 101** LSC K0144	
ID Prefix	Correction Completed **04/01/2015**	ID Prefix	Correction Completed **04/01/2015**	ID Prefix	Correction Completed **04/01/2015**
Reg. # **NFPA 101** LSC K0147		Reg. # **NFPA 101** LSC K0154		Reg. # **NFPA 101** LSC K0155	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/mm	06/01/2015	28120	05/28/2015
Reviewed By **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/25/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245289	A. Building B. Wing 01 - MAIN BUILDING 01	2/12/2015

Name of Facility	Street Address, City, State, Zip Code
CRYSTAL CARE CENTER	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0072	Correction Completed **02/10/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** PS/mm	**Date:** 06/01/2015	**Signature of Surveyor:** 28120	**Date:** 05/28/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 1/7/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 245289

March 11, 2015
By Certified Mail and Fax

Ms. Annette Thorson, Administrator
Crystal Care Center
3245 Vera Cruz Avenue North
Crystal, MN 55422

Dear Ms. Thorson:

SUBJECT: FEDERAL MONITORING SURVEY RESULTS AND NOTICE OF IMPOSITION OF REMEDY
Cycle Start Date: January 9, 2015

STATE SURVEY RESULTS
On January 7, 2015, a life safety code survey and on January 9, 2015, a health survey were completed at Crystal Care Center by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. These surveys found that your facility was not in substantial compliance, with the most serious deficiencies at scope and severity (S/S) level F, cited as follows:

- F456 -- S/S: F -- 483.70(c)(2) -- Essential Equipment, Safe Operating Condition
- F465 -- S/S: F -- 483.70(h) -- Safe/functional/sanitary/comfortable Environment
- F520 -- S/S: F -- 483.75(o)(1) -- QAA Committee-Members/meet Quarterly/Plans
- K67 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K72 -- S/S: F -- NFPA 101 -- Life Safety Code Standard

In its notice dated January 26, 2015, the Minnesota Department Of Health informed you that your facility could avoid the imposition of remedies if substantial compliance was achieved by February 18, 2015. The State agency subsequently accepted your allegation of compliance and revisited your facility on February 12, 2015. As the State agency informed you, that visit also revealed that your facility was not in substantial compliance, with the most serious deficiency cited as follows:

- K67 -- S/S: F -- NFPA 101 -- Life Safety Code Standard

The State agency advised you of the deficiencies that led to this determination and provided you with a copy of the survey reports (CMS-2567).

FEDERAL MONITORING SURVEY
Subsequently, a surveyor representing this office of the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility on February 25, 2015. As the surveyor informed you during the exit conference, the FMS has revealed that your facility continues to

not be in substantial compliance. The FMS found deficiencies, with the most serious being at S/S level F cited as follows:

- K0012 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K0017 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K0020 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K0025 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K0046 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K0048 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K0050 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K0052 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K0054 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K0062 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K0066 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K0067 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K0144 -- S/S: F -- NFPA 101 -- Life Safety Code Standard

The findings for the FMS are enclosed on form CMS-2567.

ELECTRONIC PLAN OF CORRECTION (ePOC)
Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the enclosed deficiencies cited at the FMS. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice;
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur;
- The date that each deficiency will be corrected; and
- An electronic acknowledgement signature and date by an official facility representative.

INFORMAL DISPUTE RESOLUTION
The State agency offered you an opportunity for informal dispute resolution (IDR) following its survey visits. A request for IDR will not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

CMS has established an informal dispute resolution (IDR) process to give providers one opportunity to informally refute deficiencies cited at a Federal survey, in accordance with the regulation at 42 CFR 488.331. To use this process, you must send your written request, identifying the specific deficiencies you are disputing to, Stephen Pelinski, Branch Manager, at the Chicago address shown above. The request must set forth in detail your reasons for disputing each deficiency and include copies of all relevant documents supporting your position. A request for IDR will not delay the effective date of any

enforcement action, nor can you use it to challenge any other aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

You must submit your request for IDR within the same ten (10) calendar day timeframe for submitting your ePOC. You must provide an acceptable ePOC for all cited deficiencies, including those that you dispute. We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

LIFE SAFETY CODE (LSC) WAIVERS

If you request an annual waiver for a LSC deficiency cited during the FMS, the request must indicate why correcting would impose an unreasonable hardship on the facility; if high cost is the hardship, you must include recent, bona fide cost estimates. In addition, the request must indicate how continued non-correction of the deficiency will not pose a risk to resident safety, based on additional compensating features or other reasons.

Each cited deficiency (other than those which receive annual waivers) must be corrected within a reasonable timeframe. If a reasonable correction date falls beyond your enforcement cycle's three month date, you may request a temporary waiver to allow correction by the reasonable date, and without the noncompliance leading to the imposition of remedies. Include a request for a temporary waiver as part of your POC, indicating the basis for the length of correction time needed, and include a timetable for correction. A temporary waiver may be granted if the POC date extends beyond your enforcement cycle's three month date, and if the correction timeframe is reasonable, in CMS' judgment. Your enforcement cycle's three month date is April 9, 2015.

SUMMARY OF ENFORCEMENT REMEDIES

As a result of the survey findings, we are imposing the following remedy:

- Mandatory Denial of Payment for New Medicare & Medicaid Admissions effective April 9, 2015

The authority for the imposition of remedies is contained in subsections 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

DENIAL OF PAYMENT FOR NEW ADMISSIONS

Mandatory denial of payment for all new Medicare admissions is imposed effective April 9, 2015 if your facility does not achieve compliance within the required three months. This action is mandated by the Social Security Act at Sections 1819(h)(2)(D) and 1919 (h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). We are notifying National Government Services that the denial of payment for all new Medicare admissions is effective on April 9, 2015. We are further notifying the State Medicaid agency that they must also deny payment for all new Medicaid admissions effective April 9, 2015.

You should notify all Medicare and Medicaid residents admitted on or after this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance

or your provider agreement is terminated. Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payment for new admissions.

TERMINATION PROVISION

If your facility has not attained substantial compliance by July 9, 2015, your Medicare and Medicaid participation will be terminated effective with that date. This action is mandated by the Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

We are required to provide the general public with notice of an impending termination and will publish a notice in a local newspaper prior to the effective date of termination. If termination goes into effect, you may take steps to come into compliance with the Federal requirements for long term care facilities and reapply to establish your facility's eligibility to participate as a provider of services under Title XVIII of the Social Security Act. Should you seek re-entry into the Medicare program, the Federal regulation at 42 CFR Section 489.57 will apply.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $5,000.00; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by April 9, 2015, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Crystal Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 9, 2015. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

APPEAL RIGHTS

This formal notice imposed:

- Mandatory Denial of Payment for New Medicare & Medicaid Admissions effective April 9, 2015

If you disagree with the findings of noncompliance which resulted in this imposition, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. seq.

You are required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/. To file a new appeal using DAB EFile, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the

bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB EFile is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

- Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking **Civil Remedies Division** on the File New Appeal screen.
- Entering and uploading the requested information and documents on the "File New Appeal- Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked **E-Filing Instructions** after logging-in to DAB E-File.

For questions regarding the E-Filing system, please contact E-File System Support at **OSDABImmediateOffice@hhs.gov** or at 202-565-0146.

Please note that **all** hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

A request for a hearing must be filed no later than 60 days from the date of receipt of this notice.

It is important that you send a copy of your request to our Chicago office to the attention of Jan Suzuki.

CONTACT INFORMATION

If you have any questions regarding the Federal Monitoring LSC survey, please contact Bruce Wexelberg, Safety Engineer, at (312) 353-2859. Bruce Wexelberg's fax number is (443) 380-6756. For questions regarding this enforcement case, please contact Jan Suzuki, Program Representative, at (312) 886-5209. Information may also be faxed to (443)380-6602. All correspondence should be directed to Jan Suzuki in our Chicago office.

Sincerely,

Tamika J. Brown
Acting Branch Manager
Long Term Care Certification
& Enforcement Branch

Enclosure: Statement of Deficiencies (CMS-2567)

cc: Minnesota Department of Health
Minnesota Department of Human Services
Office of Ombudsman for Older Minnesotans

Kleppe, Anne (MDH)

From: Sheehan, Pat (DPS)
Sent: Friday, February 06, 2015 2:51 PM
To: rochi_lsc@cms.hhs.gov
Cc: Rexeisen, Robert (DPS); Annette Thorson (athorson@diamondhcm.com); Smith, James G (DPS); Dietrich, Shellae (MDH); Fiske-Downing, Kamala (MDH); Henderson, Mary (MDH); Johnston, Kate (MDH); Kleppe, Anne (MDH); Leach, Colleen (MDH); Whitney, Marian (DPS); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject: Crystal Care Center (245289) K67 Annual Waiver Request - Previously Approved - No Changes

Categories: Package

This is to inform you that I am accepting Crystal CC's request for an annual waiver for K67, corridors as a plenum. The exit date was on or about 1-7-15.

I am recommending that CMS approve this waiver request.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

June 1, 2015

Ms. Annette Thorson, Administrator
Crystal Care Center
3245 Vera Cruz Avenue North
Crystal, Minnesota 55422

Re: Reinspection Results - Project Number S5289026

Dear Ms. Thorson:

On March 17, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 9, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00255	A. Building B. Wing	3/18/2015

Name of Facility	Street Address, City, State, Zip Code
CRYSTAL CARE CENTER	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 **20255** Reg. # **MN Rule 4658.0070** LSC	Correction Completed **02/10/2015**	ID Prefix **20435** Reg. # **MN Rule 4658.0210 Subp.** LSC	Correction Completed **02/06/2015**	ID Prefix **20560** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **02/10/2015**
ID Prefix **20920** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **02/10/2015**	ID Prefix **21015** Reg. # **MN Rule 4658.0610 Subp.** LSC	Correction Completed **02/10/2015**	ID Prefix **21025** Reg. # **MN Rule 4658.0615** LSC	Correction Completed **02/15/2015**
ID Prefix **21325** Reg. # **MN Rule 4658.0725 Subp.** LSC	Correction Completed **02/10/2015**	ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp.** LSC	Correction Completed **02/15/2015**	ID Prefix **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	Correction Completed **02/15/2015**
ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1** LSC	Correction Completed **02/10/2015**	ID Prefix **21665** Reg. # **MN Rule 4658.1400** LSC	Correction Completed **02/13/2015**	ID Prefix **21670** Reg. # **MN Rule 4658.1405 A.B.C.I** LSC	Correction Completed **02/10/2015**
ID Prefix **21705** Reg. # **MN Rule 4658.1415 Subp.** LSC	Correction Completed **02/10/2015**	ID Prefix **21800** Reg. # **MN St. Statute144.651 Sub** LSC	Correction Completed **02/10/2015**	ID Prefix **21810** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **02/10/2015**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/mm	06/01/2015	30923	03/18/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00255	A. Building B. Wing	3/17/2015

Name of Facility	Street Address, City, State, Zip Code
CRYSTAL CARE CENTER	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 **21870** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **02/10/2015**	ID Prefix **21880** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **02/10/2015**		

Reviewed By _____ **State Agency**	**Reviewed By** GL/mm	**Date:** 06/01/2015	**Signature of Surveyor:** 30923	**Date:** 03/18/2015
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 1/9/2015	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 89GV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00255

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245289**
2.STATE VENDOR OR MEDICAID NO.
(L2) **604140000**

3. NAME AND ADDRESS OF FACILITY
(L3) **CRYSTAL CARE CENTER**
(L4) **3245 VERA CRUZ AVENUE NORTH**
(L5) **CRYSTAL, MN** (L6) **55422**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/20/2013**

6. DATE OF SURVEY **01/09/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **130** (L18)

13.Total Certified Beds **130** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B,5*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	130			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Facility's request for a continuing waiver involving Tag K067 is recommended.

17. SURVEYOR SIGNATURE Date :
Douglas Stevens, HFE NE II 02/10/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 02/19/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1984
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00000
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 5629

January 26, 2015

Ms. Annette Thorson, Administrator
Crystal Care Center
3245 Vera Cruz Avenue North
Crystal, Minnesota 55422

RE: Project Number S5289026 and Complaint Number H5289044

Dear Ms. Thorson:

On January 9, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the January 9, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5289044.

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 January 9, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5289044 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>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

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

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gayle.lantto@state.mn.us
Telephone: (651) 201-3794
Fax: (651) 201-3790

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 February 18, 2015, 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 February 18, 2015 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 April 9, 2015 (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 July 9, 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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING _____ B. WING _____	01/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL CARE CENTER	**3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An investigation of complaint H5289044 was conducted at the time of the recertification survey and was found unsubstantiated.	F 000		
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the	F 156		2/10/15

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

Electronically Signed | 02/09/2015

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

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F 156	Continued From page 1 items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State	F 156		

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F 156	Continued From page 2 ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure appropriate notice of the right to request a demand bill when Medicare was discontinued was provided as required for 2 of 3 residents (R56, R40) reviewed for liability notice. Findings include: R56 was admitted to the facility on 6/4/14, after a qualifying hospitalization and required rehabilitation therapy. R56 was discharged from Medicare non-coverage on 7/24/14, and was discharged from the facility on 7/25/14.	F 156	The residents at Crystal Care Center have been given notice as required. The correct form was obtained to document that residents can request a demand bill. The policy and procedure regarding liability notices was reviewed and revised. Staff who were likely to deliver Medicare notices will be in-serviced regarding which forms to use and 48 hours notice will be given. To monitor, the DON designee will check discharge files for residents who have been removed from Medicare during the preceding month and report on the	

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F 156	Continued From page 3 On 7/14/14, at 3:24 p.m. a nursing note indicated that R56 was asked to sign a Medicare denial notice. The note indicated the resident refused to sign the notice, stating her son signed everything on her behalf. A telephone message was left for R56's son. Nursing notes did not reflect further attempts made to contact R56's son for a signature on the denial notice. According to a CMS 10123 form, R56's services ended on 7/24/14, and it was noted R56 refused to sign the form. The form did not indicate whether R56's son was informed services would be ending, since R56 had previously reported her son signed all paperwork on her behalf. On 1/9/15, at 2:44 p.m. the health information manager (HIM) explained that R56's services ended on 7/24/14. The CMS 10123 form for R56 was reviewed and a Post-it note was attached that read, "refused to sign." The form lacked documentation showing R56 had been provided a 48-hour notice as required before Medicare non-coverage date. R40's Medicare part A services ended on 9/12/14, and the resident was discharged from the facility on 9/13/14, according to an interview with the HIM on 1/9/14, at 4:19 p.m. On 1/9/15, at 4:19 p.m. the HIM explained that R40 had not been provided a denial notice, as the resident requested to be discharged on 9/13/14, before her coverage would have ended. On 1/9/15, the Minimum Data Set Medicare coordinator explained there was no other available documentation available related to liability notices for R56 or R40.	F 156	completion rates to the Quality Committee.	

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F 156	Continued From page 4 A policy on liability notices was requested, but none was provided.	F 156		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure appropriate follow-up to resident concerns for 1 of 3 residents (R5) whose family member reported non-resolution to a reported missing item. Findings include: R5's family member (FM)-A was interviewed on 1/6/15, at 2:15 p.m. When asked if R5 had been missing any personal belongings, FM-A replied, "Yes." FM-A stated her mother's watch had been missing for a couple of months now. Although she had reported this to a licensed practical nurse (LPN)-B, the watch had not been found and no staff member followed-up regarding her reported concern. A follow-up interview was conducted with FM-A on 1/9/15, at 1:58 p.m. FM-A explained that during a care conference in 10/14, she reported R5's was missing a watch to LPN-B. FM-A stated that she was not given the option to fill out a missing items report or a grievance form. FM-A	F 166	Resident R5 was interviewed by Social Service and a grievance form completed and circulated with no result. The facility offered to replace the item and the resident declined. An article regarding how to report concerns will be placed in the weekly newsletter which is posted for all residents, visitors, and staff. The policy and procedure regarding resident concerns was reviewed and revised. All staff will be in-serviced regarding how to properly follow up on resident concerns by February 10, 2015. To monitor, Social Services will inquire of residents and families at care conferences as to whether they have had any concerns and inform them as to how to report in between care conferences.	2/10/15

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F 166	Continued From page 5 stated that the missing watch was never found and no one had ever followed up to let her know whether the watch had been found, "so I just gave up on it." On 1/8/15, at approximately 12:15 p.m. the third floor nursing station missing items clip board was reviewed. Several items were listed on the board as "missing," however, several items were not dated indicating the item had been found. Following the review of the clip board, both LPN-A and a nursing assistant (NA)-C both said they would have reported a missing item to the supervisor. Neither LPN-A or NA-C were aware a resolution form should have been filled out, or that items were tracked using the missing items clip board. An activity staff (AS)-A was then interviewed and stated she was unaware of a report R5's watch had been missing. On 1/8/15, at 1:12 p.m. a licensed social worker (LSW)-A stated if a resident items were missing, staff were to fill out a resolution form, found at all nursing stations. The form was to then be submitted to a LSW who reviewed for form, and informed the resident's family, administrator, and director of nursing. LSW-A explained that other staff were made aware of the missing items via verbal communication and word of mouth. LSW-A was unaware of R5's missing watch, and could not find a resolution form regarding the watch. LSW-A said missing items were looked into for a week or two, and then the LSW would follow up. If the item was not found, the family was informed. Should the family chose to replace the item, the facility would reimburse them. On 1/8/15, at 2:54 p.m. LPN-B stated staff were	F 166	Social Services will collect the forms and report on them monthly in the Quality Committee and any patterns identified will be followed up by the Committee.	

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F 166	Continued From page 6 notified of missing items via a progress note as well as on the missing item clip board located at the nursing station. LPN-B stated that staff persons were trained on the facility's system for reporting missing items from the LSWs. LPN-B stated she was unaware R5's watch was missing. On 1/8/15, at 1:41 p.m. the director of nursing (DON) stated the steps for tracking a missing item was as follows: Once a concern form was filled out it was given to the LSW. The missing item was discussed at the nursing meeting and other staff was informed about the missing item through verbal communication from the nurse managers. The DON stated that the LSW was responsible for following up regarding missing items. On 1/9/15, at approximately 4:00 p.m. the infection control nurse stated she trained all newly hired staff as to how to report missing items and in filling out the concern forms. The facility's 2009 policy for Completing the Suggestion or Problem Resolution Form indicated concerns, "will be reviewed by the Executive Director and given to the appropriate department head. The person assigned to investigate and resolve the issue will complete the resolution form in the area, plan of resolution and follow-up comments after review with the concerned party. If the person is not satisfied with the resolution, they will contact the Executive Director, who will evaluate the outcome with the customer."	F 166		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility	F 244		2/10/15

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F 244	Continued From page 7 must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a formalized system to ensure residents and families were encouraged to bring up concerns and those concerns were tracked and received follow-up. This had the potential for affecting those residents or their representatives who may have wished to voice a grievance. Findings include: The director of nursing was interviewed regarding the facility's grievance system on 1/7/15, at 10:35 a.m. She stated she was unaware of a facility system of tracking concerns. On 1/8/15, at 2:20 p.m. the DON stated concern forms had recently been made available after an observation was made that completed forms were not being received. It was discovered the forms had not been made available for "quite a while--possibly months." The DON said an "education piece" was needed regarding concerns, including what needed to be completed related to the concerns, etc. She was unaware whether the facility had solicited information from residents and families, such as via satisfaction surveys. Although the DON encouraged people to call her if they had concerns, said the system was "not as formalized as it needs to be."	F 244	Resident R5 was interviewed by Social Service and a grievance form completed and circulated with no result. The facility offered to replace the item and the resident declined. An article regarding how to report concerns and grievances will be placed in "News You can Use" a weekly newsletter that is posted for residents, visitors, and staff the week of Feb. 9. The policy and procedure regarding resident concerns was reviewed and revised. The Concern and Problem Resolution form was revised to indicate directions for anonymous reporting. All staff will be in-serviced regarding how to properly follow up on resident concerns by February 10, 2015. The Director of Social Services will ask for an invitation to the March Resident Council meeting to explain the grievance and concern procedure and will also bring this up at the next attempt to have a Family Council meeting by the end of May, 2015. To monitor, Social Services will collect the forms and report on them monthly in the Quality Committee and any patterns identified will be followed up by the	

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F 244	Continued From page 8 The quality manager was interviewed on 1/8/15, at 9:39 a.m. When asked how residents and families were encouraged to report concerns, she said they could tell the supervisor. Regarding anonymously reporting, the manager said the concern report could be given to a NA. When pointed out it would then not have been considered anonymous the manager said it was a "good question." She did not know of a place to drop off reports such as a suggestion box, but said it was a good idea. A Concern and Problem Resolution Form supply and drop off box was observed adjacent to the first floor reception desk. The form read, "...We welcome your suggestions, comments, and/or concerns. This form may be used to provide the information regarding your suggestion/concern to us without fear of discrimination or reprisal. We will respect your confidentiality and provide you a follow-up response. Once you have completed this form, please give it to any of our Social Workers or department managers." The bottom of the form asked who had completed the form, etc. It did not indicate the drop off box could be used or that it was an option for complainants to remain anonymous (although follow-up with the complainant would then not have been possible). The back of the form detailed investigative and follow-up measures. A licensed social worker (LSW)-A was interviewed on 1/9/15, at 1:20 p.m. regarding the facility's system for soliciting concerns from residents and families, and ensuring follow up to those concerns. LSW-A said both LSWs were new to the facility, and although they did not have a formalized system for tracking concerns and bringing them to the quality committee for review,	F 244	Committee.	

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F 244	Continued From page 9 they did note some concerns in residents' nursing notes. They also asked residents and families if they had concerns at quarterly resident care conferences. The residents had invited the LSWs to their resident council meeting, but then did not recall a specific reason they had been invited to attend. The LSWs asked the residents if they had concerns, but did not ask any specific probing questions. Although resident rights were not covered in the meeting, they "reminded them of that." The facility had considered sending out satisfaction surveys "just to kind of track that on discharges." It was felt they would get more honesty if a resident was no longer living at the facility. LSW-A had heard some of the residents were a little afraid to complain, but the LSW tried to reassure them and to show follow up if they did report a concern. LSW-A said most of the concerns went to the DON and the LSWs received mostly missing property. "It's not a precise process right now" and staff was not tracking or following up on missing property. "With the whole reconstructing thing [new management staff] we are doing things the way they had it, and making the assumption it's getting done." The facility's 9/10 Concern or Problem Resolution Policy indicated residents, families, or other concerned individuals "may complete a Concern or Problem Resolution Form as a means of communicating their problems/and receiving follow-up from the facility...Grievances can be submitted to the social worker, Executive Director/Residence Director, or any manager/supervisor."	F 244		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246		2/10/15

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F 246	Continued From page 10 A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not ensure a specialized call light was provided for 1 of 1 resident (R163) who was unable to use a standard call light. Findings include: R163 was observed while lying in bed on 1/8/15, at 11:25 a.m. a ball shaped call light was attached to left side head of the bed. When asked if he could use the call light, R163 lifted up his hand and bent his fingers attempting to grasp the ball shaped call light and shook his head back and forth voicing "no" he was unable to activate the call light. Admission Minimum Data Set (MDS) dated 12/24/14, indicated R163 was moderately cognitively impaired, had a diagnosis of cancer, and required extensive staff assistance with cares. On 1/8/15, at 11:35 a.m. a licensed practical nurse (LPN)-B stated, "I brought in a specialized pancake flat call light in for [R163] yesterday." LPN-B also stated she had asked R163 to show if he could use the pancake like call light and R163	F 246	The correct call cord was placed in the resident room on Jan. 5. Other residents who might have a similar need were reviewed by nursing management staff and it was decided there were no additional residents with special needs for call lights. All staff will be trained on providing special need call lights and correct call light usage and placement by Feb. 10,2015 Call lights will be audited daily for one week for operation, placement, and appropriateness. Then 3 times per week for four weeks, then if there appear to be no problems, call lights will be audited quarterly and reported to the quality committee. Audits will be conducted by nurses assigned by the DON.	

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F 246	Continued From page 11	F 246		

was able to put his hand on the flat call light and activate it.

On 1/9/15, at 9:45 a.m. R163's call light was inaccessible. R163 was lying in bed with a flat shaped call light attached snuggly in between the outside of the mattress and the left quarter side rail. Following the observation at 9:49 a.m. LPN-F verified the resident would not have been able to access the light. LPN-F stated, "This flat call light is more sensitive than the standard push button call light. The flat call light should be placed somewhere here" and LPN-F pointed toward the top of R163's abdomen. LPN-F then placed the flat call light on R163's abdomen and near R163's hand and instructed R163 regarding the call light placement and R163 lifted up his hand and placed on flat call light and activated call light.

Nursing assistant (NA)-B was asked on 1/9/15, at 9:50 a.m. about differences between standard and specialized call lights. The NA was unaware of any differences in call lights.

At 9:55 a.m. LPN-F explained when R163 came in to the facility he was much stronger and was able to utilize a standard push button call light, but now could not.

At 10:01 a.m. LPN-G stated, "I knew [R163] could not push the standard push button call light, so I called physical therapy and told them. That is when the ball shaped call light for him [R163] was put in."

A 12/18/14, hospice visit summary note, "Recommended [R163] had a pancake call light as he was too weak for a standard call light."

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F 246	Continued From page 12 A nursing progress note dated 12/23/14, read "Resident [R163] reported to writer that he does not use call light" because it was hard to press the button. "Maintenance was left a voice message with requests for pad call light. Request was also placed on maintenance clip board." A nursing progress note dated 1/7/15, read "Resident [R163] bed was changed and a flat (pancake-like) call light ordered." The care plan also dated 1/7/15, indicated R163 was to have a pancake call light. On 1/9/15, at 10:56 a.m. the director of nursing stated she expected residents' call lights to be within their reach and she also expected staff to follow residents' care plans.	F 246		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure residents were informed of roommate changes prior to the change taking place for 2 of 3 residents (R9, R28) who were reviewed for room/roommate changes. Findings include: R9 reported when interviewed on 1/5/15, at 4:04 p.m. staff had said nothing to him prior to his	F 247	The Social Service staff were reminded on 1/12/15 to notify all residents affected by room changes and to document their discussion prior to the room change especially residents who will receive new roommates. A policy and procedure for room changes was revised to provide more specific directions on rooms changes on Feb. 3,	2/6/15

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F 247	Continued From page 13 getting a new roommate. R9 stated, "They just brought the young man in." R9's quarterly Minimum Data Set (MDS) dated 12/2/14, indicated he was cognitively intact. R28 stated on 1/5/14, at 4:38 p.m. a new roommate moved in about a month ago and no notice was given to him before the roommate change. R28's annual MDS dated 12/2/14, indicated he was cognitively intact. On 1/9/15, at 11:05 a.m. a licensed social worker (LSW)-B stated, "The facility lets the current resident discuss and know about any roommate changes before the new roommate moves in. I believe it is charted in the progress notes. It is social services that talks to the resident about any possible room changes." Regarding R28 LSW-B said, "I talked to [R28] about his new roommate." Documentation of notification for R9 and R28's roommate changes was then requested, but was not provided by LSW-B. LSW-A was interviewed on 1/9/15, at 12:58 p.m. and explained, "Right now social services and admissions [staff] talk to residents about roommate changes. There is no documentation--it is mostly verbal."	F 247	2015. A room change checklist was revised to include that documentation of new roommate notification occurs by Feb. 4, 2015. To audit, the Director of Social Services will review all room changes that occur during the month to ensure that room change notifications occur as required. The results will be reported at Quality Committee monthly.	
F 254 SS=E	483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 254	New sheets were present in storage and	2/10/15

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F 254	Continued From page 14 review, the facility failed to ensure linens were in good repair and an adequate supply was available in 5 of 6 linen closets and to ensure bed linens were routinely changed. Findings include: On 1/5/15, at 11:43 a.m. while completing an initial tour of the facility, resident beds in rooms 321, 322 and 326 were striped clean of any bed linens. Pillows, blankets and bedspreads were piled in the middle of the beds. On 1/5/15, at 4:02 p.m. R64's fitted sheet on his bed was observed to be very thin appearing with approximately eight quarter inch holes along the side of the fitted sheet. On 1/6/15, at 12:54 p.m. R105's fitted sheet of his bed was observed to very thin appearing and many small holes along the side of the fitted sheet. A housekeeper (H)-B was asked about the facility's system for stripping beds on 1/8/15, at 9:10 a.m. H-B reported the housekeepers were responsible for stripping beds according to a list. When asked where the list was kept H-B responded, "I think" there was one in the soiled utility room. She then brought the surveyor to the utility room where a posted listing showed three or more room numbers for different days of the week. H-B said she stripped and then washed the beds if needed, and then the NAs were supposed to remake the beds. When she found sheets that were thin and worn and/or had holes she threw them away. R110 expressed concerns with the facility's	F 254	put into service. Additional washcloths, hand towels, and bath towels were ordered on Jan. 12 and put into service on Jan. 19. An inventory of all facility linens occurred on Jan. 27. Additional linens were ordered based on inventory results. All linen closets will be cleaned and re-organized so that a wide variety of linen is available on each wing of the building by February 13, 2015. Policies and procedures were developed to remove thin and worn items, communicate to the director for ordering, and place into service so that linen is replaced. Involved staff will be in-serviced on the policies and procedures by Feb. 10, 2015. The Environmental Services Director and the Executive Director will monitor through regular checks of the linen closets.	

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system for linen changes on 1/8/15, at 1:56 p.m. She reported she did not like the manner in which beds were stripped and explained that the housekeeper stripped the bed stacking the pillows and bedspread on the soiled laundry bin and chairs in the room. The nursing assistants (NAs) made the bed when they had time. "It irritates me. I don't like it at all." R110 felt it would have been more appropriate to have the NA strip and then make the bed, because they did not necessarily have time to make the beds at the time they were stripped, therefore the bed remained unmade and residents could not lie down as they wished. In addition R110 stated, "In the last year I don't know what happened to the wash rags...In the evening or late afternoon there aren't any," and described the facility as being "dangerously low on them."

The DON reported on 1/8/15, at 2:25 p.m. she believed linens were changed on bath days. A licensed practical nurse (LPN)-D informed the DON at 2:39 p.m. that the facility "used to have bed makers." The DON then asked a registered nurse (RN)-A at 2:40 p.m. about the facility's system for changing bed linens. RN-A reported bed linens were changed "when obviously soiled." The DON then stated, "On bath days," to which RN-A replied they "do it with the bath-type thing." When the surveyor asked for clarification RN-A stated bed linens were changed "when they are soiled." At 2:44 a health unit coordinator (HUC)-A was asked by the DON if she knew the facility's system for stripping bed linens. HUC-A said she believed "laundry strips so many beds each day," and said there used to be a list of those rooms in the linen closets. The DON looked in the linen closet, but was unable to locate the list. The surveyor then showed her the list in the soiled

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utility room. The DON responded, "Looks like we need to work on that system too. That's not good." The DON had not heard of a linen issue, but was aware there had been a problem at times with staff throwing the wash cloths away with the soiled linen. Observations of the six linen closets on the three floors were then conducted with the DON and linen was available/unavailable as follows:

1) 1 north closet contained no wash cloths, no hand or bath towels, two pillow cases, one gown, four blankets, no bedspreads, and one sheet;

2) 1 south closet was the most fully stocked of all six closets and included a stack of approximately 30-35 wash cloths and a supply of bath towels and sheets, one gown, two pillow cases, and no hand towels. The DON said she was unsure whether hand towels were usually available or only bath towels;

3) 2 north closet contained no wash cloths, no hand or bath towels, no gowns, no bedspreads, five sheets, three pillow cases;

4) 2 south closet one wash cloth, bath towels but no hand towels;

5) 3 north closet contained one sheet and three blankets, but no other linen;

6) 3 south closet one wash cloth, bath towels but no hand towels.

On 1/8/15, at 1:35 p.m. R105's bed remained stripped of linen and the bedspread, blanket, and pillow were piled at the end of the bed. There was a spill of water pooled on the end of the

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F 254	Continued From page 17 mattress near the piled linens. No staff could be found in the area. A licensed practical nurse (LPN)-C who worked on the other end of the floor was asked to assist R105. She was unsure how the water got onto the mattress. On 1/9/15, at 10:17 a.m. a housekeeper (H)-C reported there was no set times for picking up linens, and the last time he had picked up linens for washing was at approximately 9:00 a.m. At 10:43 a.m. HK-C was observed delivering clean linen to the third floor linen closet. When the linen closet was opened, it contained only 10 bath blankets. Washcloths, towels, and other bedding had been unavailable prior to the delivery. Policies regarding linen handling and bed stripping were requested on 1/9/15, but were not provided.	F 254		
F 257 SS=E	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident rooms were maintained at a comfortable temperatures in 4 of 33 rooms observed affecting five residents (R160, R106, R4, R54, R104) when either complaints were registered regarding and/or observations revealed cool temperatures.	F 257	The Environmental Services Director adjusted the boiler for windchill on 1/7/15. Window problems were repaired in the room for R160 on the same day. A mechanical contractor came to the facility on Jan. 14 to provide information to the Director of Environmental Services on operating the boiler and the auxiliary room	2/13/15

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F 257	Continued From page 18 Findings include: An environmental tour was conducted with the administrator and the director of environmental services (DES) on 1/7/15, at 2:00 p.m. The outside temperature was below zero, and temperatures in resident rooms were taken when some of the residents complained they were cold. The maintenance director was in his first week of employment. He explained the facility's boiler system had a built-in windchill factor adjustment, but he had found it had not been set accordingly. All temperatures were taken at the floor level: 1) R160's room registered 66 degrees Fahrenheit (F). The DES reported a draft could be felt at the upper corner of the window. 2) R84's room registered 65 degrees F and the resident complained he felt cold. 3) R54 and R4's room registered 63 degrees. Both residents in the room complained of being cold. R54 stated, "It's cold in here! I'm cold!" R4 said he had resided in the room for some time and it had always been "the coldest room in the building." The DES, administrator, and surveyor all agreed the room felt chilly. The DES explained that each resident room had an individual thermostat. He made adjustments to each of the thermostats in the rooms that were checked, and said there was still room to increase the temperature, but perhaps staff were not making the appropriate adjustments when complaints were voiced regarding room temperatures. R104's family member (FM)-C approached the nursing desk on 1/8/15, at 11:21 a.m. and stated emphatically to a registered nurse (RN)-A and the surveyor, "I want you both to come back to my mother's room and see how cold it is! See if you	F 257	heating units. A second company came in on Jan. 19 to clean auxiliary units in five rooms identified during the tour with positive results. The facility maintenance department will clean and assess auxiliary units in resident rooms going forward on an annual basis or upon a concern being expressed. Maintenance will monitor these rooms and others at random, but especially on days when outdoors it is zero or below windchills until it is determined that a problem no longer exists. All staff will be in-serviced by February 10 regarding how to report problems to the Maintenance Department. All scheduled staff will be in-serviced during the week of Feb. 9 on how to adjust a resident room thermostat. A small card will be posted in each room next to the thermostat with instructions for staff and residents on how to adjust thermostats for heating and cooling. To monitor, temperature logs will be reviewed by the ESD and the Administrator weekly.	

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F 257	Continued From page 19 think you would want your 90 year old mother to be in a room that cold!" RN-A and the surveyor then both observed the room and agreed it felt chilly. RN-A adjusted two thermostats in the room. RN-A then notified the DES the problem, and requested he return to the room in two hours to ensure the room temperature was comfortable. RN-A then informed the surveyor that residents, family members, and staff may not have known how to check the room temperatures or make adjustments to thermostats for residents' comfort. The administrator reported at the start of the environmental tour that the facility had not been utilizing a preventive maintenance plan. On 1/8/15, at approximately 4:30 p.m. the administrator said that after the previous DES recently left employment all policies related to maintenance appeared to be missing.	F 257		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise	F 279		2/10/15

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F 279	Continued From page 20 be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan for 1 of 3 residents (R20) who had identified dental needs. Findings include: R20's Care Area Assessment dated 11/5/14, revealed dental problem described as "broken or loosely fitting full or partial denture" and noted the resident was at risk for nutritional problems. The care plan dated 11/12/14, identified potential problem with nutritional status. Among the interventions was to observe for changes in chewing and eating abilities. The care plan did not address R20's dental problem. R20 was interviewed on 1/7/15, at 10:57 a.m. at which time the resident acknowledged and showed the surveyor she was missing many lower teeth and had no upper teeth. R20 stated she had an "upper plate" but did not wear it, instead kept it "in a drawer somewhere." When asked why the dentures were not worn R20 replied, "Because it hurts." R20 was unsure if facility staff knew about the ill-fitting dentures. On 1/7/15, at 11:59 a.m. a licensed practical nurse (LPN)-E stated he had observed R20's many missing teeth. However, LPN-E verified a care plan had not been developed regarding the	F 279	A care plan was completed for R20. A list of residents who were identified on the MDS as needing dental attention was made, their care plans were audited and updated as needed. Nurses performing dental assessments for the MDS were asked to alert the nurse manager to add that resident to the list for dental services when needed. At the initial and quarterly care conferences, the resident will be asked if they have a need or desire for dental services. All nursing staff will be in-serviced by February 10, 2015 to notify the nurse manager of resident dental needs. To monitor audits will be performed by Director of Nursing designee and follow up action will be taken as appropriate.	

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F 279	Continued From page 21 issue, nor had a referral been made to the dentist. On 1/8/15, at 11:15 a.m. R20's daughter, FM-B stated the facility had never consulted her regarding dental care for R20. FM-B was unaware of any care plan interventions regarding R20's dental status. On 1/9/15, at 10:33 a.m. the director of nursing stated she expected staff nurses to follow up on problems identified during the comprehensive assessment, then develop a care plan and implement interventions according to that plan. The facility's Care Plan Policy and Procedure dated 8/10, directed staff to "gather information on admission and continue over the next 14 days, develop a comprehensive care plan that contains both strengths and dependencies; should have problem and goal statements, and interventions; interventions should be individualized and written to help meet goal; a discipline or department responsible to meet the goal should be identified; and the care plan would only be complete after it was reviewed during care conference with the resident and responsible party."	F 279		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced	F 312		2/10/15

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F 312	Continued From page 22 by: Based on observation, interview and document review, the facility failed to ensure shaving was provided for 1 of 1 resident (R12) who was reviewed for activities of daily living (ADL) and who was totally dependent on staff. Findings include: R12 was observed on 1/6/15, at 6:14 p.m. with approximately half inch long white facial hairs on her chin. The following day at 7:52 a.m. the facial hair remained on the resident's chin. R12's admission record identified diagnoses including paralysis on one side of the body and aphasia (inability to express and understand language). R12's care plan dated 10/19/14, and annual Minimum Data Set (MDS) dated 12/30/14, indicated the resident was severely cognitively impaired, and required total assistance with ADLs. On 1/7/15, at 9:17 a.m. a nursing assistant (NA)-C stated that she had provided morning care for R12, and that she should have also shaved the resident's facial hair but had "missed it." On 1/8/15, at 2:54 p.m. a licensed practical nurse (LPN)-B stated R12 required staff assistance of one person to provide daily grooming including shaving.	F 312	Staff caring for R12 were in-serviced to provide shaves as needed daily on 1/7/2015. A policy and procedure regarding grooming was reviewed and revised by Feb. 5, 2015. All nursing staff will be in-serviced by Feb. 10, 2015. To monitor, nurse managers will audit on a daily basis during rounds and advise staff to correct immediately as needed.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		2/10/15

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F 323	Continued From page 23 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure side rails were securely fixed to minimize the risk of accidents for 1 of 17 sampled residents (R35) who utilized side rails. Findings include: R35's side rails were observed on her bed on 1/7/15, at 9:40 a.m. The left bed rail was loose and could be pulled away from the frame and could be easily moved back and forth three to four inches. At the time of the observation R35 said she would have used the rail, but "It's loose...unsafe and I am scared to use it." R35 was admitted on 11/11/14. The resident's care plan dated 12/11/14, indicated R35 was at risk for falls, was impulsive, and required assistance of one staff person for ambulation and transfers, but was independent with turning and repositioning. On 1/9/15, at 1:17 p.m. a nursing assistant (NA)-G stated that although she had provided care for R35, she had not noticed the bed rail was loose. On 1/9/15, at 1:26 p.m. a housekeeper (H)-A stated she noticed R35 bed rail was loose a few	F 323	We do not use side rails at Crystal Care Center. The assist rail for R35 was tightened on 1/9/2015. Maintenance has checked all assist bars for needed repairs. A system was devised to check assist rails on an ongoing basis and involved staff will be in-serviced by 2/10/15. All staff will be in-serviced by 2/10/15 about how to report maintenance needs to the Maintenance Department. To monitor, random checks will be conducted by the Environmental Services Director or the Executive Director.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 24 days prior, and had it reported it to floor nurse. H-A could not recall the name of the nurse to whom it had been reported. At 1:32 p.m. a licensed practical nurse (LPN)-F explained that R35 needed help sitting up in bed and the LPN had not noticed the loose rail. At 1:39 p.m. LPN-B stated she was also unaware of the loose rail, and denied receiving a report as such. LPN-B and the director of environmental services (DES) then both observed the rail and confirmed it needed to be repaired. The DES stated that if equipment needed repair, staff was to write it down on the maintenance log at the nursing station and leave a message on the DES's phone. On 1/9/15, at approximately 1:50 p.m. the maintenance requests sheet were reviewed from 10/14/14 to 1/6/15 and indicated nowhere was it indicted R35's bed rail was loose. On 1/9/15, at approximately 4:30 p.m. the administrator said that after the previous DES recently left employment all policies related to maintenance appeared to be missing.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329		2/10/15

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F 329	Continued From page 25 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a rationale for the continued use of antipsychotic medication in absence of an appropriate diagnosis, as well as identification and target behavior monitoring for 1 of 5 residents (R76) reviewed for unnecessary medication. Findings include: R76 was observed resting in his room on 1/7/15 at 11:15 a.m. and again at 1:25 p.m. He answered a few questions posed to him in a quiet, slightly mumbling voice with his eyes sometimes closed. He reported he "could be better," and when asked to elaborate said he felt nauseated. The following day at 9:19 a.m. R76 was again lying in bed, and he in a soft spoken voice reported not feeling well, but was unable to pinpoint why.	F 329	R76 has rationale for the medications that are prescribed. A list of all residents on antipsychotic medications was audited to make sure that appropriate diagnoses are in place. The Quality Committee met on January 22 and decided to develop a checklist to use for anti-psychotic drug orders to ensure that all requirements are met for these medications. We have a medication reduction committee in place that meets regularly for each floor. We will use the above described checklist to ensure that residents have all of the requirements prior to the meeting, and use it in monitoring any changes that are made.	

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F 329	Continued From page 26 R76 had diagnoses according to the resident's face sheet including dementia with behavioral disturbances, depressive disorder with recurring episodes, anxiety, and other persistent mental disorder due to conditions classified elsewhere. R76's Minimum Data Set (MDS) dated 9/24/14 revealed the resident had moderately impaired cognition. Mood and behavioral issues were not identified. In a subsequent quarterly MDS (dated 12/23/14), although the resident continued to have moderately impaired cognition, his score went from the high end of 11, to the low end of eight or one point from severe cognition. Behavioral issues were again not identified, but the addition of the presence of multiple mood indicators were. These included little interest, feeling down, sleeping too much or too little, little energy, and trouble concentrating. A consultant pharmacist reviewed R76's medications on 10/8/14. No irregularities were identified. It was noted the antipsychotic Seroquel had been discontinued and Zyprexa had been started for unspecified "delusions." R76's 1/15 physician orders included Zyprexa 2.5 milligrams (mg) every 12 hours and 5 mg at bedtime for "for dementia", Remeron 45 mg for depression, and clonazepam 0.5 mg twice daily for anxiety. In addition, R76 also had multiple scheduled medications for constipation. A nursing order directed staff to monitor R76's anxiety level, perseverating on bowels, presence/absence of bowel movements, and secluding self in room were to be monitored, but was not associated with a particular medication. For antidepressant use, staff were directed to monitor mood problems such as sad, withdrawn	F 329	All nursing staff will be in-serviced by 2/10/15 to make sure that any anti-psychotic drug orders have an appropriate diagnosis. This will be monitored by random audits conducted using the checklist, making corrections as needed, and reporting to the Quality Committee.	

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and mood changes, as well as several side effects including stiff neck, tremors, confusion, etc.

A licensed practical nurse (LPN)-D indicated on 1/8/15, at 9:29 a.m. that R76 perseverated on bowel movements. He reported constipation when he was actually not and thought Milk of Magnesia (for constipation) "is a magic solution." LPN-D explained R76 had not been eating well for a while, but since an increase in his Zyprexa (antipsychotic) and Klonopin (anti-convulsant commonly used for anxiety) he had been eating better and a slight improvement was noted in his mood. LPN-D said staff re-directed the resident when he perseverated to a topic such as sports and therapeutic recreation staff took him to down to the facility store. R76 could become very anxious about what was served at mealtime, and "If there's no prune juice, we'll run down and get it for him." The staff had implemented a system with the physician of validating his bowel movements via a log on the bathroom wall, "but that didn't work for him."

On 1/8/15, at 10:32 a.m. LPN-E indicated some changes in R76's medication had been tried. "He had used to do better so we cut some meds [medications] a little. He declined more and so we increased some meds back toward how it was before to optimize [his treatment]." LPN-E described the resident as being very complex and was "pretty conscious of not being well." Most recently his psychotropic medications were increased and other general medications were decreased.

LPN-D said on 1/9/15, at 12:35 p.m. R76 had remained about the same regarding his anxiety

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and seclusion, and said the behaviors varied from day to day and/or at different times of the day. When asked for evidence of identification and monitoring of target behaviors related to the use of the Zyprexa, LPN-D said she thought it would be on the Treatment Administration Record (TAR). LPN-D was only able to locate information regarding the antidepressant medication, Remeron. LPN-D asked, Could you put Zyprexa in the same category with Remeron?"

During an interview on 1/9/15, at 1:31 p.m. a housekeeper (H-B) reported R76 was in his room sleeping most of the time.

On 1/9/15, at 1:39 p.m. LPN-D verified R76 experienced a fall on 12/30/14, and explained his gait was unsteady and he had tripped over another resident's walker.

On 1/9/15 at 1:44 p.m. a nursing assistant (NA)-F reported R76 was shaky, which had improved some than when he first came to the unit. She had noticed increased confusion.

LPN-E stated on 1/9/15, at 1:45 p.m. R76's TAR should have included specific behaviors/delusions the staff were to monitor, but was not being monitored. In addition, orthostatic blood pressures (blood pressure readings taken lying, sitting and standing after a period of rest that may have indicated a sudden drop in readings) should have been taken since the resident had been prescribed an antipsychotic medication. LPN-E stated, "I don't see any on his orders, but I will add them."

The director of nursing was interviewed on 1/91/5, at 1:50 p.m. and stated she would have

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F 329	Continued From page 29 expected target behavior monitoring when antipsychotic medication was used, as well as appropriate side effect monitoring, including orthostatic blood pressures. During a telephone interview on 1/9/14, at 2:03 p.m. the consulting pharmacist (CP)-A stated, "I would expect 'delusional disorder' as an indication" for antipsychotic use. In addition, he would expect staff to have identified and monitored target behavior and medication side effects.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the	F 334		2/10/15

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F 334	Continued From page 30 influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.	F 334		

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F 334	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure evidence 1 of 5 residents (R59) or their legal representative was provided received the required education regarding the benefits and potential side effects of the influenza immunization prior to administering the vaccination. Findings include: R59's immunization record was on 1/8/15, at approximately 2:00 p.m. and required immunization information could not be found. The facility's infection control nurse reviewed the record at 2:36 p.m. and reported R59 had been vaccinated for influenza on 10/30/14. The nurse could not provide documentation that R59 received the risk and benefits information prior to the administration of the influenza immunization. The facility's undated Resident Immunization and Vaccination Standing Protocol directed staff to ensure consent had been obtained from the resident or the resident's decision maker, and document the consent in the resident's record.	F 334	Resident R 59 did receive an influenza vaccination. The resident received the risks and benefits form but this was not documented. The policy and procedure has been reviewed and revised. Nursing staff will be in-serviced on the correct policy and procedure for documenting vaccinations by Feb. 10, 2015. This will be monitored by a Director of Nursing Designee ongoing during flu season through completing audits of residents receiving vaccinations and reporting results to the Quality Improvement Committee.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and	F 356		2/10/15

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F 356	Continued From page 32 unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nursing hours were posted as required, potentially affecting all 101 residents and visitors to the facility. Findings include: Observations on staff posting were conducted at the facility from 1/5/15 to 1/9/15 each day the surveyor entered the building. The facility licensed and nursing assistant staffing information was posted on a board adjacent to	F 356	Nursing hours were posted on all days of the survey. A new nursing hours form was devised to better comply with the regulation. It was put into service on Feb. 2, 2015. A policy and procedure was developed on 1/23/15. Staff who need to complete the form will be in-serviced on the policy, procedure, and use of the form by 2/10/15.	

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F 356	Continued From page 33 the reception area. Although the information included the number of staff by discipline including registered nurses, licensed practical nurses, trained medication aides and nursing assistants by shift, the posting lacked the actual hours worked by the licensed and unlicensed direct care staff. On 1/8/15, at 1:41 p.m. the director of nursing (DON) stated that she was aware of the information required on the daily posting. The DON then reviewed the posting and verified the total number and actual hours worked by licensed and unlicensed direct care staff was missing from the posting. On 1/8/15, at 2:38 p.m. staffing personnel verified that she completed the daily staff posting and was unaware that the posting required the number of actual hours worked by licensed and unlicensed direct care staff. On 1/9/15, at 4:30 p.m. DON reported a facility policy regarding the posting of nursing hours was unavailable.	F 356	To monitor, the DON will audit the form several times weekly to ensure that it is being completed correctly until we are certain that the requirement is being met.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		2/10/15

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F 371	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was held at the proper temperature in steam tables on the third floor and second floor north, potentially affecting 57 residents residing on those units. In addition, refrigerators, freezers, and microwaves were not kept clean on all units, and staff reported inconsistencies as to who was responsible for the cleaning. This had the potential to affect all 101 residents residing in the facility. Findings include: Improper food temperatures: On 1/5/15, at 6:20 p.m. in the third floor dining room temperatures of the residents' food were taken by a dietary aide (DA)-G at the request of the surveyor. The fish patties, pureed food and mechanical soft food registered 100 degrees and the water holding the food containers registered 90 degrees. These temperatures were verified by DA-G. DA-G stated, "I was going to give the next resident the fish patty because he is mechanical soft level 3." DA-G also stated he had just served a mechanical soft diet for a room tray at approximately 6:15 p.m. DA-G reported he had left the food covers off of the food Cambro serving unit throughout the entire service, said the food should have been held at 160 degrees. At 6:24 p.m. the certified dietary manager (CDM) explained that the third floor dining service was different from the other floors. Cambro insulated containers were utilized to serve the residents'	F 371	A steam table for 3rd floor was ordered on 1/8/15. It is placed into use on 2/6/2015. Covers were ordered for current steam and Cambro serving trays so that food can be held at hotter temperatures. Dietary staff were in-serviced on the importance of keeping covers in place as much as possible on 1-27-15 Refrigerators, freezers, and microwaves were cleaned on 1/9/15. A policy and procedure outlining that Dietary is responsible for cleaning the dining room equipment was put into place and all staff will be trained by February 10, 2015. To monitor, the Nutritional Services Manager will check appliances for cleanliness on a regular basis and correct immediately if problems are found. Temperature logs will be maintained for food temperatures and randomly reviewed by the Nutritional Services Manager for safe temperatures.	

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food, and on first and second floors steam tables were used. The CDM also stated the water holding the food should be at 180 degrees and the food temperatures needed to be held at 160 degrees. The CDM manager further stated it took a full hour to serve food on third floor.

On 1/6/15, at 9:04 a.m. in the third floor dining room covers were observed on the containers (Cambro, insulated) holding food waiting to be served. Upon request, DA-C took food temperatures. The water registered 120 degrees, hot cereal 120 degrees, scrambled eggs 110 degrees and oatmeal 130 degrees. DA-C said she had started serving breakfast at 7:30 a.m. and approximately twelve residents from the third floor had yet to be served breakfast as it was an open breakfast until 9:30 a.m. At 9:05 a.m. the CDM explained third floor served an open breakfast for two hours and foods should have been kept warm and maintained at 160 degrees plus. At 9:06 a.m. DA-C stated, "The eggs, oatmeal and hot cereal are already cold and I will have to heat this food up in the microwave." At 9:15 a.m. the CDM stated, "I am getting a couple of quotes on purchasing a new steam table."

On 1/6/15, at 10:33 a.m. R137 was asked standardized interview questions regarding whether the food tasted good and looked appetizing. R137 replied, "The fish is half cooked, the fish is not done." As far as whether food was served at the proper temperature R137 answered, "The fish is cold as hell." R137 resided on the third floor, and his quarterly Minimum Data Set dated 10/21/14, indicated he had moderately impaired cognition.

On 1/6/15, at 12:25 p.m. in the third floor dining

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room DA-C upon request took the temperatures of the food served from Cambro containers. DA-C measured the temperatures of the food. The mashed potatoes measured 110 degrees, ground ham 96 degrees, peas 80 degrees and steak patties were 80 degrees. DA-C was just about to serve R6 the steak patty, and R22 ground ham, peas and mashed potatoes when the surveyor intervened. DA-C verified R6 and R22's food was cold and reheated the food in the microwave. At 12:38 p.m. the CDM stated he would have expected the residents received food warm enough, and said residents could request food be warmed in the microwave.

On 1/7/15, at 9:27 a.m. in the third floor dining room DA-C was about to serve R64 her breakfast when surveyor observed no visible steam coming up from the oatmeal. DA-C upon request took the breakfast food temperatures. Pureed eggs, scrambled eggs, and pureed bread all registered 110 degrees and oatmeal 140 degrees. The surveyor then tasted all the foods served and found they were not warm, nor palatable. DA-C stated R64 was a "feeder" and said "feeders are served last" because they did not want the food sitting in front of them as it would get cold while they waited for assistance to eat. DA-C stated she would reheat R64's food before serving. A nursing assistant (NA)-D stated she would reheat R163's scrambled eggs, oatmeal, and toast in the microwave because the food was cold. NA-D said R12 was a "feeder" as well, and she would reheat her scrambled eggs, toast and oatmeal. NA-G reheated R33's scrambled eggs, oatmeal and toast. At 9:43 a.m. DA-C had R64's breakfast reheated in the microwave as it was not warm enough to be served. At 9:44 a.m. R47's scrambled eggs, oatmeal and pureed bread was

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reheated in the microwave by NA-G and NA-G reported R47 was a "feeder." At 9:47 a.m. DA-C stated she was finished serving breakfast and said breakfast service usually went past 9:30 a.m. DA-C also stated R6 and R22 received room trays at approximately 9:00 a.m.

On 1/8/15, at 9:14 a.m. DA-D stated there were five residents yet to eat breakfast on the third floor. Upon request DA-D checked the food temperatures in the steam table. DA-D verified the pureed egg temperature registered 135 degrees, pureed toast 140 degrees, and the oatmeal 140 degrees.

On 1/9/15, at 9:20 a.m. DA-E stated, "This steam table is better than the Cambro." DA-E reported eight residents had not yet been served breakfast. Upon request DA-E checked the temperature of the food in the steam table. DA-E was provided instruction to ensure the thermometer did not touch the bottom or sides of the metal pan, and instead to ensure it was toward the middle of the food being tested. The Cream of Wheat measured 110 degrees, pureed eggs 128 degrees, pureed toast 140 degrees, oatmeal 145 degrees, and scrambled eggs 150 degrees. DA-E also reported, "The temperatures were 180 and 160 degrees when I started this morning." The bottom of the pans of food were not be touching the water, and only approximately 3/8 inches of water was in the bottom of the steam table. DA-E verified the pans of food were not touching the water. DA-E said she did not know how much water should have been in the steam table. She said she obtained the hot water from the unit sink, "but not too hot." DA-E stated she had two residents' mechanical soft diets to yet serve as well as R47 who was prescribed a

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F 371	Continued From page 38 pureed diet. DA-E stated she pulled back the plastic wrap and foil off the pans, and did not replace the covers on the pans during the food service period. DA-E explained, "I only have one cover and I do not use it to cover any food." At 9:34 a.m. DA-E checked the temperature of the water and it registered 120 degrees. On 1/9/15, at 10:20 a.m. the CDM stated the bottom of the pans of food for service should have been covered by at least an inch of water and that the serving pans. In addition, pans should have been left covered when food was not being served. The CDM added, "I have to buy some new covers as we need more." Unclean equipment: On 1/5/15, at 11:56 a.m. in the second floor freezer, food crumbs and a sticky yellowish substance was observed throughout the bottom and sides of the freezer. Ice cream, possible and waffles were observed in the freezer which was verified by NA-E. NA-E stated dietary and housekeeping staff were responsible for cleaning the unit refrigerators and microwaves. The second floor unit microwave was had dirty with food specks and brownish stains throughout top and bottom. On 1/5/15, at 3:42 p.m. the third floor dining room unit refrigerator had blackish dirty food marks on outside of refrigerator and freezer under the handles. Spilled juice and sticky shelves were observed throughout. Packages of french toast opened, pancakes, waffles and individual ice creams for the residents were stored for use in the freezer.	F 371		

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F 371	Continued From page 39 On 1/5/15, at 5:15 p.m. the first floor dining room unit refrigerator inside was observed to have food splattering's. DA-H stated dietary staff usually cleaned unit refrigerators on the day shift and added, "Sometimes they don't get done." The microwave on the first floor unit also was observed with crumbs on the microwave shelf and food markings on the inside door. On 1/7/15, at 10:06 a.m. DA-C reported housekeeping staff was responsible for cleaning the unit refrigerators and microwaves. On 1/8/15, at 9:40 a.m. the second floor north unit refrigerator had food spills inside on the door shelf and food marks on the outer door of the refrigerator. Large, yellow-juice like spill was again observed in the freezer shelf. Individual ice containers were stored in the freezer. The unit microwave had brown food particles observed throughout the bottom and top of the microwave. At 9:46 a.m. in the freezer in the second south dining room was observed red juice spills and crumbs on the shelf. DA-F stated white and chocolate milk is kept in the unit refrigerators for the residents between meals. NA-H stated, "Fourteen residents eat here for meals, evenings will use the milk in the refrigerator for snacks for the residents." On 1/8/15, at 12:12 p.m. the CDM stated housekeeping cleaned the unit microwaves and dietary cleaned the unit refrigerators and freezers. The CDM stated dietary performed daily checks, generally on the day shift. The CDM also stated that he did not have cleaning checklists for the dietary staff to follow or check off as his staff knew what to do.	F 371		

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F 371	Continued From page 40 On 1/8/15, at 1:15 p.m. the CDM stated, "I ordered a set of dietary policies and procedures because we did not have any since the old management took them." At 3:29 p.m. the CDM reported, "I ordered a new steam table." On 1/9/15, at 9:41 a.m. DA-E stated dietary cleaned the unit refrigerator and freezers, but not the microwaves. DA-E then added that dietary staff cleaned the first floor microwave. The facility provided a 6/05 Food Temperature, Dietary Resource Manual. Under directions it read, "The following are suggested BEST PRACTICE temperature guidelines and do vary according to individual food item and resident preference. GOAL TEMPERATURES Hot Items Prior to Serving equal to or greater than 160 degrees, Point of Dining equal to or greater than 140 degrees. *Regulation requires hot food to be held at equal to or greater than 140 degrees. Although there is no stated temperature for serving in Federal Regulations, it is stated that food must be palatable and appropriate in temperature per resident preference. Adjust serving temperature upward for satellite service to assure adequate temperature at point of dining."	F 371		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a	F 411		2/10/15

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F 411	Continued From page 41 Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure follow up when a dental problem was identified for 1 of 3 residents (R20) reviewed for dental needs. Findings include: R20 was interviewed on 1/7/15, at 10:57 a.m. at which time the resident acknowledged and showed the surveyor she was missing many lower teeth and had no upper teeth. R20 stated she had an "upper plate" but did not wear it, instead kept it "in a drawer somewhere." When asked why the dentures were not worn R20 replied, "Because it hurts." R20 was unsure if facility staff knew about the ill-fitting dentures. The Admission Record indicated R20 was admitted in 10/14. A Care Area Assessment dated 11/5/14, revealed dental problem described as "broken or loosely fitting full or partial denture" and noted the resident was at risk for nutritional problems. Although the staff did not plan to address the dental issue on the care plan, it was noted a referral would be made to "onsite dental." However, R20's medical record lacked evidence the referral was completed.	F 411	A care plan was completed for R20. A list of residents who were identified on the MDS as needing dental attention was made, their care plans were audited and updated as needed. Nurses performing dental assessments for the MDS were asked to alert the nurse manager to add that resident to the list for dental services when needed. At the initial and quarterly care conferences, the resident will be asked if they have a need or desire for dental services. All nursing staff will be in-serviced by February 10, 2015 to notify the nurse manager of resident dental needs. To monitor audits will be performed by Director of Nursing designee and action taken to follow up as appropriate.	

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F 411	Continued From page 42 R20's care plan dated 11/12/14, identified potential problem with nutritional status. Among the interventions was to observe for changes in chewing and eating abilities. The care plan did not address R20's dental problem. On 1/7/15, at 11:59 a.m. a licensed practical nurse(LPN)-E stated he had observed R20's many missing teeth. However, LPN-E verified a care plan had not been developed regarding the issue, nor had a referral been made to the dentist. LPN-E stated he would call R20's family to check if they would consent to a dental visit. On 1/8/15, at 11:15 a.m. R20's daughter, FM-B stated the facility had never consulted her regarding dental care for R20. FM-B was unaware of any care plan interventions regarding R20's dental status. On 1/9/15, at 10:33 a.m. the director of nursing stated she expected staff nurses to follow up on problems identified during the comprehensive assessment, then develop a care plan and implement interventions according to that plan.	F 411		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		2/10/15

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F 428	Continued From page 43 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the pharmacist identified medication irregularities related in appropriate diagnosis and monitoring of antipsychotic medication for 1 of 5 residents (R76) reviewed for unnecessary medication use. Findings include: A consultant pharmacist reviewed R76's medications on 10/8/14. No irregularities were identified. It was noted the antipsychotic Seroquel had been discontinued and Zyprexa had been started for unspecified "delusions." R76 had diagnoses according to the resident's face sheet including dementia with behavioral disturbances, depressive disorder with recurring episodes, anxiety, and other persistent mental disorder due to conditions classified elsewhere. R76's 1/15 physician orders included Zyprexa 2.5 milligrams (mg) every 12 hours and 5 mg at bedtime for "for dementia", Remeron 45 mg for depression, and clonazepam 0.5 mg twice daily for anxiety. In addition, R76 also had multiple scheduled medications for constipation. A nursing order directed staff to monitor R76's anxiety level, perseverating on bowels, presence/absence of bowel movements, and secluding self in room were to be monitored, but was not associated with a particular medication. For antidepressant use, staff were directed to monitor mood problems such as sad, withdrawn and mood changes, as well as several side	F 428	R76 has rationale for the medications that are prescribed. A list of all residents on antipsychotic medications was audited to make sure that appropriate diagnoses are in place. The Quality Committee met on January 22 and decided to develop a audit tool to use for anti-psychotic drug orders to ensure that all requirements are met for these medications. We have a medication reduction committee in place that meets regularly for each floor. We will use the above described audit to ensure that residents have all of the requirements prior to the meeting, and use it in monitoring any changes that are made. All nursing staff will be in-serviced by 2/10/15 to make sure that any anti-psychotic drug orders have an appropriate diagnosis. This will be monitored by the nurse managers by auditing new admissions and any anti- psychotic medication changes on a weekly basis.	

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F 428	Continued From page 44 effects including stiff neck, tremors, confusion, etc. LPN-D said on 1/9/15, at 12:35 p.m. regarding evidence of identification and monitoring of target behaviors related to the use of the Zyprexa, she thought it would be found on the Treatment Administration Record (TAR). LPN-D was only able to locate information regarding the antidepressant medication, Remeron. LPN-D asked, Could you put Zyprexa in the same category with Remeron?" LPN-E stated on 1/9/15, at 1:45 p.m. R76's TAR should have included specific behaviors/delusions the staff were to monitor, but was not being monitored. In addition, orthostatic blood pressures (blood pressure readings taken lying, sitting and standing after a period of rest that may have indicated a sudden drop in readings) should have been taken since the resident had been prescribed an antipsychotic medication. LPN-E stated, "I don't see any on his orders, but I will add them." The director of nursing was interviewed on 1/91/5, at 1:50 p.m. and stated she would have expected target behavior monitoring when antipsychotic medication was used, as well as appropriate side effect monitoring, including orthostatic blood pressures. During a telephone interview on 1/9/14, at 2:03 p.m. the consulting pharmacist (CP)-A stated, "I would expect 'delusional disorder' as an indication" for antipsychotic use. In addition, he would expect staff to have identified and monitored target behavior and medication side effects.	F 428		

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F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 431	The expired medications were removed	2/10/15

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F 431	Continued From page 46 review, the facility failed to ensure expired medications were not stored for use for six residents (R83, R59, R6, R98, R84, R9) as well as expired house stock triple antibiotic ointment. Medication was not labeled when opened for three residents (R20, R46, R21). In addition, medication carts were observed unclean with spills and loose pills in the drawers on four of six units, potentially affecting an additional 83 residents. Findings include: Expired medication stored for use: Four packets of triple antibiotic ointment which expired in 2013 were stored for use on the medication cart on two south. A licensed practical nurse (LPN)-D verified the finding at the time of the observation on 1/8/15, at 12:30 p.m. The 3 east medication cart was inspected with LPN-F on 1/8/15, at 1:58 p.m. The following was noted: Two containers of Ventolin HFA 90 micrograms (mcg) for asthma labeled for R83 with the first container expired on 12/6/14 and the second container expired on 1/5/15; and R59's Ventolin HFA 90 mcg for asthma expired on 10/8/14. The 3 west medication cart was inspected on 1/8/15, at 2:00 p.m. The following was observed: R6's Vitamin C 500 milligram (mg) expired on 9/14 and R98's Centrum dietary supplement expired on 10/14. LPN-H verified the findings at the time of the observation. The 1 west medication cart was inspected on 1/8/15, at 2:30 p.m., an approximate half-full	F 431	on 1/8/2015. The staff were reminded to keep medication carts clean and watch for expired medication on 1/12/15. A policy and procedure to assign medication cart cleaning and removal of expired medications was completed. All nursing staff will be in-serviced on above by 2/10/15. Medication carts will be audited for expired meds, cleanliness, and to ensure appropriate date opened markings three times per week for four weeks. After that, weekly for two weeks and then monthly.	

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F 431	Continued From page 47 bottle of R84's aspirin 81 mg expired on 12/28/14 and was stored for use. LPN-I verified the findings at the time of the observation. The 1 east medication cart was inspected on 1/8/15, at 2:45 p.m. and R9's Atrovent HFA inhaler which expired on 1/12/15 was still in the cart. LPN-A verified the findings at the time of the observation. Un-labeled medication: During inspection of 2 north medication cart with LPN-H on 1/7/15, at 2:00 p.m., R20's opened bottle of Nitrostat 0.4 mg for chest pain was not labeled when opened. A bottle of Nitrostat also had no label for expiration date. During inspection of 3 west medication cart with LPN-H on 1/8/15, at 2:00 p.m., R46's opened ear drops bottle was not labeled with an opened date. During inspection of 1 east medication cart with LPN-I on 1/8/15, at 2:30 p.m., R21's Advair Diskus 100/50 mcg for asthma was found opened without an opened date noted on the medication container. Dirty medication carts: The 2 north medication cart was inspected on 1/7/15, at 2:20 p.m. with LPN-H. The second drawer of the medication cart was dirty with several small pieces of foil paper and a moderate amount of spilled white powdery substances. The second drawer's first and second compartments each had four loose pills and the third compartment had six loose pills. The pills were on the drawer floor.	F 431		

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F 431	Continued From page 48 The 2 south medication cart was inspected with LPN-D on 1/8/15, at 12:30 p.m. The back of the cart's second drawer was dirty with spilled white powdered substances. The middle compartment had seven loose small pills on the floor and the right compartment had one loose pill. The 3 east medication cart was inspected and observed on 1/8/15, at 1:58 p.m.. The cart was dirty with thick white powder on the floor and had six loose pills on the floor of the drawer. The 3 west medication cart was inspected with LPN-H on 1/8/15, at 2:00 p.m. The back part of the second drawer was dirty with white powdered substances and a total of seven loose pills were observed on the drawer floor of the three compartments. On 1/9/15, at 10:33 a.m. the director of nursing (DON) stated she expected staff nurses to clean up after themselves and for nurse managers to check for expired medications in the carts and discard appropriately. On 1/9/15, at 2:03 p.m. the consultant pharmacist stated expired medications should not have been stored for use in medication carts. The facility's 9/10, Storage of Medication policy directed staff that outdated or discontinued medications would be "immediately removed from stock and disposed according to medication disposal procedures. In addition, medication storage should be kept clean, organized and free of clutter; and staff were directed to monitor conditions of medication storage on a regular basis as a random quality assurance check."	F 431		

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F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		2/15/15

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F 441	Continued From page 50 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene was implemented for 1 of 6 (R108) whose personal cares were observed. Findings include: R108 was provided morning cares by two nursing assistants (NA)-I and NA-H on 1/6/15, at 9:42 a.m. NA-I and NA-H donned gloves and checked R108's incontinent pad while the resident was lying in bed. Both NA-I and NA-H felt the inside of the incontinent pad and reported R108 did not need to be changed. NA-I and NA-H proceeded to transfer the resident using a mechanical lift into a tilt chair. Both NAs participated in providing cares including washing the resident's chest, underarms, arms, legs and peri area with a warm soapy wash cloth. Oral cares were then provided without glove changing and hand washing. When cares were completed, both NA-I and NA-H left R108's wearing the same soiled gloves. NA-I was observed to proceeded to the clean linen closet where she removed a clean towel and returned to R108's room. NA-I wet the towel with warm water and was about to wash R108's face when the surveyor intervened. NA-I verified she had not removed her gloves or washed her hands at appropriate times during personal cares for R108. NA-H was observed walking down the hallway toward the dining area. NA-H removed her gloves, but did not perform hand washing. NA-H proceeded to the dining room and the surveyor intervened to stop NA-H before she began	F 441	The nursing assistants caring for R108 were reminded of proper glove use and hand washing on 1/6/2015. All staff will be in-serviced on proper glove use and hand washing by February 10, 2015. All scheduled direct care staff during the week of Feb. 8 will be observed for correct hand washing and proper use of gloves through Feb. 15. After that, a checklist will be made of remaining direct care staff and observations conducted until all have been reviewed. To monitor, the staff development/infection control nurse will randomly observe nursing assistant and nurses during periods of caring for residents, and other staff during other functions, and report on this to the Quality Committee monthly for 3 months, and if staff are in compliance, quarterly for one year.	

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F 441	Continued From page 51 assisting a resident with eating. NA-H verified she had not removed her gloves or washed her hands at appropriate times during and following personal cares for R108. On 1/8/15, at 2:54 p.m. a licensed practical nurse (LPN)-B stated she expected staff to perform hand washing before and after personal cares and before meal services. The facility's 2013 Standard Precautions infection control policy specified "hand washing with plain or anti-microbial soap and gloves are to be removed between resident contacts, before touching uncontaminated surfaces or other areas of the same resident's body that may be uncontaminated. The purposed is to reduce the possibility that personnel will become transiently colonized with microorganism that can be transmitted to other residents."	F 441		
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure equipment was maintained in a safe manner in the laundry area when a significant amount of lint was found in the lint traps, posing a fire hazard. This potentially affected all 101 residents. Findings include:	F 456	The lint observed by the surveyor was removed from the dryers on 1/9/2015. The staff were reminded that the policy is to remove lint at the beginning and ends of the shift and also in between on 1/9/15 and 1/12/15.	2/10/15

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F 456	Continued From page 52 The facility's laundry area was toured on 1/9/15, at approximately 8:20 a.m. with the director of environmental services (DES). Three commercial dryer were found with a significant build-up of lint on the removable lint traps. The DES explained that the screens had not been cleaned the previous day, and were to have been cleaned three times a day. The DES confirmed that all three dryers had a thick layer of lint in the traps and could have posed a potential fire hazard. On 1/9/15, at approximately 9:40 a.m. a housekeeper (H)-C reported the lint traps were cleaned at the end of each day. H-C was shown the problem with the excessive lint by the DES and was instructed to clean the traps. H-C stated the lint trap must not of been cleaned out at the end of the previous day. On 1/9/15, at 10:17 a.m. the administrator was shown the lint that had accumulated in the three dryers. According to the administrator at 4:30 p.m. policies and procedures related to maintenance appeared to be missing.	F 456	Cleaning of lint out of the dryers was placed on job duty lists and posted in the laundry room to clarify the frequency of cleaning of the lint traps. Formal in-service will be completed by 2/10/2015. To monitor, the Environmental Services Director will check the lint traps daily each shift until the laundry staff are in the habit of cleaning them regularly.	
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by:	F 463		2/10/15

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F 463	Continued From page 53 Based on observation, interview and document review the facility failed to ensure call lights were working and/or were within reach for 4 of 27 sampled residents (R70, R84, R105, R159) who were capable of summoning help via the call light. Findings include: R70's bathroom call light was not working when tested on 1/5/15, at 4:17 p.m. A nursing assistant (NA)-J verified call light in R70's bathroom was not working. At 4:42 p.m. A registered nurse (RN)-A verified R70's bathroom call light was not working and would be reporting the problem to the maintenance department. The quarterly Minimum Data Set (MDS) dated 9/23/14, indicated R70 had moderate cognitive impairment and was independent with most activities of daily living (ADLs). R86's call light was observed laying across the resident's bed. It was not working when tested on 1/5/15, at 5:25 p.m. A licensed practical nurse (LPN)-I verified the call light was not functioning, and said he would report it to the nurse manager. At 5:31 p.m. LPN-E approached the surveyor and stated he went to R86's room and found that the non-working call light light belonged to the other bed but was mistakenly placed on R86's bed. LPN-E stated he had "switched the plug and the call light worked." The other bed was unoccupied at the time. R86's MDS dated 12/9/14, indicated the resident had moderate cognitive impairment. R159's call light was observed coiled on the floor by the wall approximately four feet from the bed on 1/6/15, at 1:28 p.m. NA-A verified the call light was on the floor and out of R159's reach. NA-A stated R159 was able to and did use his call light	F 463	All call lights that were not working were repaired on on 1/5/15 or 1/6/15. All staff will be in-serviced on call light answering, call light placement within resident reach, specialty call lights, and how and where to report for call light repair by February 10, 2015. Nursing staff will be in-serviced in addition regarding facility policies for call light alternatives to keep residents safe by February 10, 2015. To monitor, regular call light audits for functioning, appropriateness, and placement will be conducted by the DON or designee daily for one week, three times a week for four weeks, and then quarterly reporting to the QA committee.	

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to summon assistance. NA-A stated, "Usually we clip his [R159's] call light on his bed."

An admission Minimum Data Set (MDS) dated 1/5/15, indicated R159 was moderately cognitively impaired.

R105 was seated in his recliner in his room on 1/8/15, at 1:35 p.m. when observed from the hallway. The recliner was located between the end of the bed and the closet. R105 was shifting his position, therefore was asked whether he needed assistance by the surveyor. He reported he was "thinking" of getting out of the recliner, but decided to "stay put." When asked how he would get help when he needed it, he reported staff would eventually come around. The call light was on the floor at the head of the bed, opposite where the resident was seated. The surveyor asked the resident was asked if he used the call light. He responded, "I don't know where the hell my call light is. Where do I find it?" The surveyor summoned a licensed practical nurse (LPN)-C, who asked R105, "Where is your call light? You always use your call light." The resident responded, "I don't know." LPN-C picked up the call light from the floor and placed it in the middle of the bed, but out of the resident's reach. When asked by the surveyor if he could reach the call light, he said he could not. LPN-C said the cord was not long enough to reach the recliner. The surveyor suggested unwinding it from behind the objects on the night stand, and then the cord reached the resident.

During an environmental tour on 1/8/15, at 2:00 p.m. the administrator explained that staff had discovered one of the two locked doors to the memory care unit was not functioning. properly

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F 463	Continued From page 55 when the keypad was loose. In addition, some call lights were also not working. The administrator said the issue with the call lights may have been reported by surveyors and was thought could have been related to the issue with the security door. An outside repair company was called and completed the necessary repairs. Additionally, six new call lights were ordered. On 1/9/15, at 10:56 a.m. the director of nursing stated she expected residents' call lights to be within their reach and she expected staff to follow residents' care plans.	F 463		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adequate housekeeping and maintenance throughout the building, potentially affecting all 101 residents residing in the facility and and visitors. Findings include: A housekeeper (H)-B was interviewed on 1/8/15, at 9:10 a.m. She reported third floor only had one housekeeper, "and that is too much for one person." H-B tried to help out when she finished the work on the floor where she worked, by emptying garbage on third floor.	F 465	The third floor of Crystal Care Center has been identified as needing re-decorating prior to the time of the survey. Decorating and architectural companies are in the process of submitting bids. We expect that the carpeting will be replaced due to the amount of wear. In the meantime, the carpeting will be cleaned on 3rd floor prior to Feb. 13, 2015. Repairs needed were made in rooms 304, 312, 316 and 321. All resident rooms will	2/13/15

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F 465	Continued From page 56 R110 said in an interview on 1/8/15, at 1:56 that staffs' hours had been cut which in turn affected the cleanliness of building. When "the census drops the cleaning staff has to go home." In addition, she alleged one of the weekend staff called in on two different Sundays because she wanted to go to church. This left no cleaning staff on the floor where the resident resided. R110 felt the housekeeping staff also needed additional training. Some examples she cited included their responsibility for stripping beds. Pillows, blankets and bedspreads were piled up around the room, including on the soiled laundry bin. The previous day R110 had also observed a housekeeper leave a vacuum cleaner in the hallway and then went on to a new task. A short time later a maintenance staff person discovered and moved the vacuum cleaner. R110's Minimum Data Set assessment dated 11/1/14, noted the resident was cognitively intact. During the environmental tour on 1/8/15, at 2:00 p.m. the administrator reported the facility had not been utilizing a preventive maintenance plan. They had just hired a new director of environmental services (DES) who had already identified numerous maintenance and housekeeping issues. The DES said the only preventive maintenance that he could see was related to major equipment, such as air handling, mechanical lifts, etc. Maintenance issues were otherwise written on a clipboard or were reported in stand-up meetings. The administrator said previously the need for painting was not noted by the DES or painters were called in at $40 an hour. There had been no systematic method of ensuring maintenance issues were addressed, such as painting. Going forward, new	F 465	be put on a schedule for deep cleaning by February 13, 2015 to be completed within 3 months. The first floor entryway is cleaned several times daily as needed to deal with salt and sand accumulation. The elevator tracks are placed on a weekly cleaning schedule. The following laundry room repairs have been made: The trash bags of clothing and other debris in the laundry room were removed on 1/9/15. The lint traps were cleaned out and laundry staff were reminded to clean out per policy several times daily. The employee hand washing sink was replaced in January. The area behind the dryers and the dryers themselves have been cleaned of dust and debris. the soiled laundry room has been cleaned and the ceiling tiles put in place. The wheel chair washing room was scraped and re-painted. Staffing levels for each floor will be reviewed by February 11, 2015 and revisions made as deemed appropriate. All staff will receive a copy of the attendance policy with paychecks on February 13, 2015. Managers have been in-serviced on enforcing attendance policies as well as the company policies regarding arrangements made for church services.	

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F 465	Continued From page 57 expectations had been laid out for the DES who was newly hired. Overall the walls and floors on the third floor were not cleaned and/or maintained. Wall paper in the hallway had numerous gouges and scrapes. The carpeting was worn near the elevators and nursing stations. Carpeting was stained and/or soiled at the elevator area and in areas near the drinking fountain. Linoleum in resident rooms was not cleaned at the edges and dust and debris was noted in the corners of the rooms as well as small nicks and holes in linoleum. Baseboards were loose particularly at edges and were pulled away from the walls. A cover outlet in room 304 was loose from the wall, and an area on the walls had been patched but was not repainted. In room 312 and 316 the doorway protective plastic was pulled away from the doors. The draft sheet inside the doorway of room 316 was pulled loose along the length of the door. The electrical box in room 321 had pulled away from the wall and was hanging loose. The DES explained that some of the beds had caught on the boxes on the wall when the beds were lowered or raised. Ventilation appeared to be working in the 3 north bathroom, however, a stale odor was detected and a the ceiling vent was covered with a heavy buildup of dust. The first floor main entryway had a large amount of salt and sand on the hallway linoleum, entry rugs, and near the elevator area at various times of the day. The DES said it required frequently cleaning due to the heavy traffic from the outside. The grooves in the elevator threshold had a heavy build-up of dirt and debris. Although hand rails throughout the building were	F 465	Staff will be in-serviced of new job duties and task lists by February 10, 2015. All staff will be in-serviced how to communicate repair and maintenance needs to the department by February 10, 2015. A basic preventive maintenance plan will be developed by February 13, 2015. To monitor, the Executive Director and Environmental Services Director will round the building and observe for cleaning and repair needs. A regular audit system will be incorporated to the Quality Committee.	

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without splinters, the finishes appeared worn. The administrator said she had been informed there were plans to have the rails replaced. In addition, the administrator reported she had been informed the owners had planned to appropriate a large amount of money toward building upgrades, but she had not yet been told any specific information regarding the plan.

During the tour of the laundry area on 1/9/15, at approximately 8:20 a.m. with the DES, the following was noted: The door to the entrance of the laundry room had a large gouge and was heavily nicked. Loose tiles were noted on the walls, and a heavy build-up of dust was observed through the area. Three dryers had a heavy build-up of lint on the removable lint vent screens. Inside the soiled utility room four ceiling tiles hung sideways down from the ceiling. A heavy build of dust was noted on the cords connected to the lighting and on top ledges around the entire utility room. The employee hand washing sink had a heavy thick, dark build-up on the bottom and sides of the sink that appeared to be dried paint. A high pile of trash bags containing discarded clothing was stored on the top of a personal-type washing machine. The inside of the machine contained a bucket of an unknown liquid chemical. Paint on the walls throughout the room where wash barrels were stored was peeled and chipped from the floor to approximately 5-6 feet.

On 1/9/15, at 10:17 a.m. the laundry area was observed with the administrator. The administrator reported the DES was responsible for deep cleaning and maintenance of the laundry area. The peeled paint had been caused by the use of high pressure hoses.

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F 465	Continued From page 59 The DES reported on 1/9/15, at 11:35 a.m. the facility did not employ a separate housekeeping and laundry supervisor, and was also his responsibility. He stated that "near as I can tell" housekeeping staffing was at four staff for 6.5 hours a day--one housekeeper for each floor and an additional staff for maintaining common areas such as the entryway, shoveling, emptying garbage, etc. On weekends, it appeared there were two housekeepers who worked 6.5 hours a day. The previous DES reportedly hired a new housekeeper just prior to his resignation, however, that person never showed up for work. It was unknown if someone had actually been hired as was reported. The DES was unaware of problems with staff not showing up on weekends, but said he was still trying to figure out the system that had been previously used. Plans were in place to immediately replace the electrical box in room 321. On 1/9/15, at approximately 4:30 p.m. the administrator said that after the previous DES recently left employment all policies related to maintenance appeared to be missing.	F 465		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify	F 520		2/10/15

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F 520	Continued From page 60 issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality committee systematically identified quality issues, and developed and implemented appropriate plans of action to correct those quality deficiencies. This potentially affected all 101 residents who resided in the facility. Findings include: The health information manager (HIM) was interviewed on 1/9/15, at 9:39 a.m. She explained she was the champion and the administrator the leader of the quality assessment and assurance (QA&A) committee, and was relatively new to the facility and the role. She was responsible for sending out an agenda one week prior to the meeting. She stated, "I pretty much follow in the footsteps of the person previously." The HIM explained the committee focused on issues they wanted to monitor or focus on such	F 520	The Quality Committee of Crystal Care Center met on January 22, 2015. A draft quality improvement plan for 2015 was approved and suggestions for additions/refinements were made and will be incorporated. The plan will include regular audits, a system for implementing plans of action to include root cause analysis, and regular follow up by the committee. It was also decided that the committee will meet monthly. The staff will be in-serviced by February 10 regarding the functions and activities of the Quality Committee at Crystal Care Center. To monitor, the Executive Director will	

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	245289	A. BUILDING _____ B. WING _____	01/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 61 as falls or promoting sleep, and they tried to maintain the culture that as long as they were focusing on something, improvement could be shown. She tracked marketing and admissions, such as trending which hospitals sent their patients for admission "so we can focus our energy on marketing." When asked how the committee identified quality issues to improve care and quality of life for the residents the HIM reported a representative was present from each department, so if there was a complaint it could be written on a Complaint and Resolution Form. Completed forms were then given to the appropriate department to handle at morning stand-up meetings. When asked how it was determined the problem had been resolved the HIM responded, "Hmmm--usually they do" [follow-up]. Feedback was given by "kudos and compliments" and the licensed social worker (LSW) tracked problems and resolutions, but they were not necessarily brought back to the committee. She was "not 100% sure where the [concern] forms go." She indicated the family council had not been very active, but resident council concerns were brought to the committee, including those that had already been resolved. The HIM said she did not think the committee wanted to "overburden with paper" and the problem was given to the pertinent department head and the director would get a copy of the complaint and the responsible person told "you deal with this--it's your problem. We just assume. I assume they are capable of solving the problem, and would assume [the administrator] follows up on this, as she's the best director I've ever met." She was unsure if the system was formalized. When asked for an example of a quality deficiency that the committee had worked on and was considered resolved the HIM said she would	F 520	ensure monthly that the planned audits will be reviewed and plans of actions developed based on results.	

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F 520	Continued From page 62	F 520		

have to do some digging. She said the director of nursing had reported on the results of expired medications in the medication carts and cleanliness of carts. Both issues, however, were found to be a problem during the survey.

The HIM verified the committee did not utilize a formalized system for tracking and maintaining long term solutions to avoid recurrences of problems.

On 1/8/15, at 10:11 a.m. LPN-D indicated she had only vague knowledge of the QA committee and its purpose. She stated she might have heard of issues the committee was working on, and what her role in their implementation would be from the nurse manager, to whom she would bring issues concerning for follow or to other department heads as needed.

LPN-E described the committed as being on 1/8/15, at 10:21 a.m. as the "state of the building address." They looked at resident issues, trends in falls, safety, and infections as topics of discussion. He admitted, "I'm not sure my staff knows anything about the committee itself, but things coming from the committee will trickle down." LPN-E was not involved in any particular project from recent quality meetings.

LPN-C said on 1/8/15, at 11:45 a.m. the quality meetings took place every two months, where department heads met to discuss things going on with the company. They looked at how to fix things. She was unsure of a specific project the committee was working on or had worked on, but could ask the nurse manager. When asked about the medication carts, LPN-C said the nurses "have our duties" including ensuring carts

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F 520	Continued From page 63	F 520		

were kept clean.

NA-A reported on 1/8/15, at 11:50 a.m. she kept "very busy with the residents" so didn't have time to "go down to meetings." She was unaware of any projects the QA committee had worked on to improve care and services for the residents.

On 1/8/15, at 11:55 a.m. NA-B said she was rather new to the facility, and was unfamiliar with the QA committee. She had enjoyed learning about the facility's "Tulip" program, where the instructed staff to show patience with residents and slow down their approaches.

A licensed social worker (LSW)-A was interviewed on 1/9/15, at 1:20 p.m. LSW-A said most concerns went to the DON and the LSWs received mostly reports of missing property. "It's not a precise process right now" and staff was not tracking or following up on missing property. "With the whole reconstructing thing [new management staff] we are doing things the way they had it, and making the assumption it's getting done." LSW-A said tracking was not currently being competed by the LSWs.

An undated document Crystal Care Center--QA&A Meeting, indicated the facility's committee met at least quarterly and required members attended.

The administrator sent additional information on 1/12/15, outlining the facility's quality improvement programs and reported the facility "is very committed to quality improvement projects and accustomed to using data" to drive those decisions to improve care for the residents. The facility had completed a nutrition/unexplained

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F 520	Continued From page 64 weight loss project and restorative sleep vitality. They continued to work on falls reduction, and had begun work on a project related to the care of residents with Parkinson's disease (including the "Tulip" program referenced by NA-B).	F 520		

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	245289	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/07/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Crystal Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/06/2015

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 3-story building was constructed in 1971 and was determined to be of Type II (222) construction. It has a full basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 130 beds and had a census of 100 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067	See Waiver request	~~2/5/15~~

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K 067	Continued From page 2 This STANDARD is not met as evidenced by: Based on observations and interviews, it could not be verified that the facility's general ventilating and air conditioning system (HVAC) is installed in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11. A noncompliant HVAC system could affect all residents. Findings include: On facility tour between 9:30 AM and 11:45 AM on 01/07/2015, observation revealed that the ventilation system has supply ducts serving the corridors without return ducts in the corridors. It appears that the only return is through the continuous operation of the resident room bathroom fans. This deficient practice was verified by the administrator at the time of the inspection.	K 067	A waiver request has been attached	
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has egress corridor obstructions which violates LSC 7.1.10. These obstructions could interfere with the convenient and effective removal of	K 072	A categorical waiver has been prepared and is in place. All staff will be in-serviced by February 10	2/10/15

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K 072	Continued From page 3 patients in an emergency situation. Findings include: On facility tour between 9:30 AM and 11:45 AM on 01/07/2015, observation revealed that there is wheeled storage in several of the resident corridors. The facility does not have a categorical waiver for wheeled storage. This deficient practice was verified by the administrator at the time of the inspection.	K 072	of the importance of not having wheeled storage in the corridor and what to do with wheeled items during fire drills and fire situations. To monitor, members of the safety committee will observe for compliance during monthly fire drills and audit on a quarterly basis for compliance in the hallways.	

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Friday, February 06, 2015 2:51 PM
To: rochi_lsc@cms.hhs.gov
Cc: robert.rexeisen@state.mn.us; Annette Thorson (athorson@diamondhcm.com); Smith, James G (DPS); Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); marian.whitney@state.mn.us; Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject: Crystal Care Center (245289) K67 Annual Waiver Request - Previously Approved - No Changes

This is to inform you that I am accepting Crystal CC's request for an annual waiver for K67, corridors as a plenum. The exit date was on or about 1-7-15.

I am recommending that CMS approve this waiver request.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

Name of Facility **2000 CODE**

Crystal Care Center-Volunteers of America, Crystal, Minnesota

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K 067 The building heating, ventilation & air conditioning equipment (HVAC) does not comply with LCS (00) Section 9.2 and HFPA 90A, 1999 edition because the corridors are being used as a plenum	Requesting to continue the Annual Wavier for K 067 approved last year. A. Compliance with this provision will cause an unreasonable Financial Hardship because: 1.The most recent cost estimate in 2013 for a complying duct HVAC system is $181,500.00 2. Existing non-complying systems can be allowed to continue in use with no adverse effect to safety. B. There will be no adverse effect on the building occupant's safety because: 1. The building is protected by a complete fire sprinkler system that complies with NFPA 13. 2. The facility corridors are equipped with a complying smoke detection system. 3.The building fire alarm system is monitored to provide automatic fire department notification. 4. The facility has a HVAC system that shuts down upon the detection of smoke. 5. Annual service and maintenance inspection/agreements exist to service all the fire protection systems. 6. Fire department stand pipes are provided in the stairways for firefighter use in case of fire. 7. Fire training is provided for all employees on an annual basis and during orientation. 8. Fire Drills are conducted quarterly on each unit.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date
	Fire Safety Supervisor	State Fire Marshal	2-6-15

BUDGETARY PROPOSAL

ALBERS
MECHANICAL CONTRACTORS

200 West Plato Boulevard, St. Paul, MN 55107 Phone 651- 224-3100 Fax 651- 265-0674

Company Name	Phone	Fax	Date
Crystal Care	763-971-6314	763-971-6340	10-28-13
Street Address	**Project Name**		
3245 Vera Cruz Avenue North	**Fresh air ducting**		
City, State, Zip	**Project Location**		
Crystal, MN 55422	**Same**		
Attention:	**Project Description**		
Mr. Dean McDevitt	**Install ducting and fire dampers**		

Albers Mechanical Contractors is pleased to offer the following quote for your review and acceptance.

Description:

- Furnish and install fire dampers at all three floors where make-up-air ductwork enters floor.
- Furnish and install ducting for fresh air in all three hallways to be connected to an exhaust fan on the roof in case of fire in building.
- Exhaust fan to be sized for the same cfm as the make-up-air unit in the boiler room.
- Note: We exclude self closing doors for individual rooms tied into fire safety system.

WE PROPOSE hereby to furnish material and labor - complete in accordance with above specifications, for the sum of:

Budget Cost: One hundred eighty one thousand five hundred dollars even$181,500.00

All material is guaranteed to be as specified. All work to be completed in a workmanlike manner according to standard practices. Any alteration or deviation from above specifications involving extra costs will become an extra charge over and above the estimate. Albers Mechanical Services will not be held liable for agreements contingent upon strikes, accidents or delays beyond our control. Building owner to carry fire, property and other necessary insurance. Our workers are covered by workmen's compensation insurance. Albers Mechanical Services will not be responsible for, nor will bid on this project, any work or cost of asbestos abatement. Building owner to provide safe work area with free access to carry out above work. Upgrading of existing systems to meet the most current codes is limited to scope of work detailed above. All work to be performed during normal workday on straight time unless otherwise noted.

Note: Proposal may be withdrawn by us if not accepted within 30 days.

Brian E. Hamilton Project Manager **Phone 651- 265-0629** **Fax 651- 265-0674**

ACCEPTANCE OF PROPOSAL - The above prices, specifications and conditions are satisfactory and hereby accepted. You are authorized to do the work as specified. Payment will be made as outlined above.

Date of Acceptance _____ Authorized Signature _____

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 5629

January 26, 2015

Ms. Annette Thorson, Administrator
Crystal Care Center
3245 Vera Cruz Avenue North
Crystal, Minnesota 55422

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5289026 and Complaint Number H5289044

Dear Ms. Thorson:

The above facility was surveyed on January 5, 2015 through January 9, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5289044 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to:

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gayle.lantto@state.mn.us
Telephone: (651) 201-3794
Fax: (651) 201-3790

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00255	A. BUILDING: _____ B. WING _____	01/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at: http://www.health.state.mn.us/divs/fpc/profinfo/inf	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00255	A. BUILDING: _____ B. WING _____	01/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL CARE CENTER	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

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2 000	Continued From page 1 obul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. An investigation of complaint H5289044 was conducted at the time of the licensing survey and was found unsubstantiated.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by:	2 255		2/13/15

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2 255	Continued From page 2 Based on interview and document review, the facility failed to ensure the quality committee systematically identified quality issues, and developed and implemented appropriate plans of action to correct those quality deficiencies. This potentially affected all 101 residents who resided in the facility. Findings include: The health information manager (HIM) was interviewed on 1/9/15, at 9:39 a.m. She explained she was the champion and the administrator the leader of the quality assessment and assurance (QA&A) committee, and was relatively new to the facility and the role. She was responsible for sending out an agenda one week prior to the meeting. She stated, "I pretty much follow in the footsteps of the person previously." The HIM explained the committee focused on issues they wanted to monitor or focus on such as falls or promoting sleep, and they tried to maintain the culture that as long as they were focusing on something, improvement could be shown. She tracked marketing and admissions, such as trending which hospitals sent their patients for admission "so we can focus our energy on marketing." When asked how the committee identified quality issues to improve care and quality of life for the residents the HIM reported a representative was present from each department, so if there was a complaint it could be written on a Complaint and Resolution Form. Completed forms were then given to the appropriate department to handle at morning stand-up meetings. When asked how it was determined the problem had been resolved the HIM responded, "Hmmm--usually they do" [follow-up]. Feedback was given by "kudos and compliments" and the licensed social worker	2 255	See Federal POC	

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2 255	Continued From page 3 (LSW) tracked problems and resolutions, but they were not necessarily brought back to the committee. She was "not 100% sure where the [concern] forms go." She indicated the family council had not been very active, but resident council concerns were brought to the committee, including those that had already been resolved. The HIM said she did not think the committee wanted to "overburden with paper" and the problem was given to the pertinent department head and the director would get a copy of the complaint and the responsible person told "you deal with this--it's your problem. We just assume. I assume they are capable of solving the problem, and would assume [the administrator] follows up on this, as she's the best director I've ever met." She was unsure if the system was formalized. When asked for an example of a quality deficiency that the committee had worked on and was considered resolved the HIM said she would have to do some digging. She said the director of nursing had reported on the results of expired medications in the medication carts and cleanliness of carts. Both issues, however, were found to be a problem during the survey. The HIM verified the committee did not utilize a formalized system for tracking and maintaining long term solutions to avoid recurrences of problems. On 1/8/15, at 10:11 a.m. LPN-D indicated she had only vague knowledge of the QA committee and its purpose. She stated she might have heard of issues the committee was working on, and what her role in their implementation would be from the nurse manager, to whom she would bring issues concerning for follow or to other department heads as needed.	2 255		

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2 255	Continued From page 4 LPN-E described the committed as being on 1/8/15, at 10:21 a.m. as the "state of the building address." They looked at resident issues, trends in falls, safety, and infections as topics of discussion. He admitted, "I'm not sure my staff knows anything about the committee itself, but things coming from the committee will trickle down." LPN-E was not involved in any particular project from recent quality meetings. LPN-C said on 1/8/15, at 11:45 a.m. the quality meetings took place every two months, where department heads met to discuss things going on with the company. They looked at how to fix things. She was unsure of a specific project the committee was working on or had worked on, but could ask the nurse manager. When asked about the medication carts, LPN-C said the nurses "have our duties" including ensuring carts were kept clean. NA-A reported on 1/8/15, at 11:50 a.m. she kept "very busy with the residents" so didn't have time to "go down to meetings." She was unaware of any projects the QA committee had worked on to improve care and services for the residents. On 1/8/15, at 11:55 a.m. NA-B said she was rather new to the facility, and was unfamiliar with the QA committee. She had enjoyed learning about the facility's "Tulip" program, where the instructed staff to show patience with residents and slow down their approaches. A licensed social worker (LSW)-A was interviewed on 1/9/15, at 1:20 p.m. LSW-A said most concerns went to the DON and the LSWs received mostly reports of missing property. "It's not a precise process right now" and staff was not tracking or following up on missing property.	2 255		

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2 255	Continued From page 5 "With the whole reconstructing thing [new management staff] we are doing things the way they had it, and making the assumption it's getting done." LSW-A said tracking was not currently being competed by the LSWs. An undated document Crystal Care Center--QA&A Meeting, indicated the facility's committee met at least quarterly and required members attended. The administrator sent additional information on 1/12/15, outlining the facility's quality improvement programs and reported the facility "is very committed to quality improvement projects and accustomed to using data" to drive those decisions to improve care for the residents. The facility had completed a nutrition/unexplained weight loss project and restorative sleep vitality. They continued to work on falls reduction, and had begun work on a project related to the care of residents with Parkinson's disease (including the "Tulip" program referenced by NA-B). SUGGESTED METHOD OF CORRECTION: The facility could ensure the quality committee has systematic measures in place to identify and address quality deficiencies. Staff could be educated. Information could be tracked to ensure follow up and resolution. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
2 435	MN Rule 4658.0210 Subp. 2 A.B. Room Assignments Room assignment complaints. A nursing home must develop and implement written policies and	2 435		2/10/15

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2 435	Continued From page 6 procedures for addressing resident complaints, including complaints regarding room assignments and roommates. At a minimum, the policies and procedures must include the following: A. a mechanism for informal dispute resolution of room assignment and roommate complaints; and B. a procedure for documenting the complaint and its resolution. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility did not ensure residents were informed of roommate changes prior to the change taking place for 2 of 3 residents (R9, R28) who were reviewed for room/roommate changes. Findings include: R9 reported when interviewed on 1/5/15, at 4:04 p.m. staff had said nothing to him prior to his getting a new roommate. R9 stated, "They just brought the young man in." R9's quarterly Minimum Data Set (MDS) dated 12/2/14, indicated he was cognitively intact. R28 stated on 1/5/14, at 4:38 p.m. a new roommate moved in about a month ago and no notice was given to him before the roommate change. R28's annual MDS dated 12/2/14, indicated he was cognitively intact. On 1/9/15, at 11:05 a.m. a licensed social worker (LSW)-B stated, "The facility lets the current resident discuss and know about any roommate changes before the new roommate moves in. I believe it is charted in the progress notes. It is	2 435	See Federal POC	

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2 435	Continued From page 7 social services that talks to the resident about any possible room changes." Regarding R28 LSW-B said, "I talked to [R28] about his new roommate." Documentation of notification for R9 and R28's roommate changes was then requested, but was not provided by LSW-B. LSW-A was interviewed on 1/9/15, at 12:58 p.m. and explained, "Right now social services and admissions [staff] talk to residents about roommate changes. There is no documentation--it is mostly verbal." SUGGESTED METHOD OF CORRECTION: The licensed social workers (LSWs) could develop and implement policies and procedures to ensure residents received required advance notice of room and roommate changes. Documentation to that effect could be maintained in the resident records. Audits could be conducted and the findings reported to the quality committee. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 435		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b).	2 560		2/10/15

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2 560	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan for 1 of 3 residents (R20) who had identified dental needs. Findings include: R20's Care Area Assessment dated 11/5/14, revealed dental problem described as "broken or loosely fitting full or partial denture" and noted the resident was at risk for nutritional problems. The care plan dated 11/12/14, identified potential problem with nutritional status. Among the interventions was to observe for changes in chewing and eating abilities. The care plan did not address R20's dental problem. R20 was interviewed on 1/7/15, at 10:57 a.m. at which time the resident acknowledged and showed the surveyor she was missing many lower teeth and had no upper teeth. R20 stated she had an "upper plate" but did not wear it, instead kept it "in a drawer somewhere." When asked why the dentures were not worn R20 replied, "Because it hurts." R20 was unsure if facility staff knew about the ill-fitting dentures. On 1/7/15, at 11:59 a.m. a licensed practical nurse (LPN)-E stated he had observed R20's many missing teeth. However, LPN-E verified a care plan had not been developed regarding the issue, nor had a referral been made to the dentist. On 1/8/15, at 11:15 a.m. R20's daughter, FM-B stated the facility had never consulted her regarding dental care for R20. FM-B was	2 560	See Federal POC	

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2 560	Continued From page 9 unaware of any care plan interventions regarding R20's dental status. On 1/9/15, at 10:33 a.m. the director of nursing stated she expected staff nurses to follow up on problems identified during the comprehensive assessment, then develop a care plan and implement interventions according to that plan. The facility's Care Plan Policy and Procedure dated 8/10, directed staff to "gather information on admission and continue over the next 14 days, develop a comprehensive care plan that contains both strengths and dependencies; should have problem and goal statements, and interventions; interventions should be individualized and written to help meet goal; a discipline or department responsible to meet the goal should be identified; and the care plan would only be complete after it was reviewed during care conference with the resident and responsible party." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could ensure policies and procedures address care planning, and appropriate staff are educated. Audits of care plans could be completed and the results brought to the quality committee meeting for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out	2 920		2/10/15

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2 920	Continued From page 10 activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure shaving was provided for 1 of 1 resident (R12) who was reviewed for activities of daily living (ADL) and who was totally dependent on staff. Findings include: R12 was observed on 1/6/15, at 6:14 p.m. with approximately half inch long white facial hairs on her chin. The following day at 7:52 a.m. the facial hair remained on the resident's chin. R12's admission record identified diagnoses including paralysis on one side of the body and aphasia (inability to express and understand language). R12's care plan dated 10/19/14, and annual Minimum Data Set (MDS) dated 12/30/14, indicated the resident was severely cognitively impaired, and required total assistance with ADLs. On 1/7/15, at 9:17 a.m. a nursing assistant (NA)-C stated she had provided morning care for R12, and that she should have also shaved the resident's facial hair but had "missed it." On 1/8/15, at 2:54 p.m. a licensed practical nurse (LPN)-B stated R12 required staff assistance of one person to provide daily grooming including shaving. SUGGESTED METHOD OF CORRECTION:	2 920	See Federal POC	

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2 920	Continued From page 11 The director of nursing (DON) or designee could develop and implement policies and procedures to ensure appropriate grooming is provided for all residents, and educate all staff. Monitoring systems could be developed to ensure ongoing compliance and report the findings to the quality committee. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 920		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure refrigerators, freezers, and microwaves were kept clean on all units, and staff reported inconsistencies as to who was responsible for the cleaning. This had the potential to affect all 101 residents residing in the facility. Findings include: On 1/5/15, at 11:56 a.m. in the second floor freezer, food crumbs and a sticky yellowish substance was observed throughout the bottom and sides of the freezer. Ice cream, possible and waffles were observed in the freezer which was verified by NA-E. NA-E stated dietary and housekeeping staff were responsible for cleaning	21015	See Federal POC	2/10/15

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21015	Continued From page 12 the unit refrigerators and microwaves. The second floor unit microwave was had dirty with food specks and brownish stains throughout top and bottom. On 1/5/15, at 3:42 p.m. the third floor dining room unit refrigerator had blackish dirty food marks on outside of refrigerator and freezer under the handles. Spilled juice and sticky shelves were observed throughout. Packages of french toast opened, pancakes, waffles and individual ice creams for the residents were stored for use in the freezer. On 1/5/15, at 5:15 p.m. the first floor dining room unit refrigerator inside was observed to have food splattering's. DA-H stated dietary staff usually cleaned unit refrigerators on the day shift and added, "Sometimes they don't get done." The microwave on the first floor unit also was observed with crumbs on the microwave shelf and food markings on the inside door. On 1/7/15, at 10:06 a.m. DA-C reported housekeeping staff was responsible for cleaning the unit refrigerators and microwaves. On 1/8/15, at 9:40 a.m. the second floor north unit refrigerator had food spills inside on the door shelf and food marks on the outer door of the refrigerator. Large, yellow-juice like spill was again observed in the freezer shelf. Individual ice containers were stored in the freezer. The unit microwave had brown food particles observed throughout the bottom and top of the microwave. At 9:46 a.m. in the freezer in the second south dining room was observed red juice spills and crumbs on the shelf. DA-F stated white and chocolate milk is kept in the unit refrigerators for the residents between meals. NA-H stated,	21015		

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21015	Continued From page 13 "Fourteen residents eat here for meals, evenings will use the milk in the refrigerator for snacks for the residents." On 1/8/15, at 12:12 p.m. the CDM stated housekeeping cleaned the unit microwaves and dietary cleaned the unit refrigerators and freezers. The CDM stated dietary performed daily checks, generally on the day shift. The CDM also stated that he did not have cleaning checklists for the dietary staff to follow or check off as his staff knew what to do. On 1/8/15, at 1:15 p.m. the CDM stated, "I ordered a set of dietary policies and procedures because we did not have any since the old management took them." At 3:29 p.m. the CDM reported, "I ordered a new steam table." On 1/9/15, at 9:41 a.m. DA-E stated dietary cleaned the unit refrigerator and freezers, but not the microwaves. DA-E then added that dietary staff cleaned the first floor microwave. SUGGESTED METHOD OF CORRECTION: The registered dietitian with the certified dietary manager could develop and implement routine cleaning procedures for cleaning equipment. Staff could be educated and audits conducted. The results could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21015		
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade)	21025		2/10/15

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21025	Continued From page 14 or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was held at the proper temperature in steam tables on the third floor and second floor north, potentially affecting 57 residents residing on those units. Findings include: On 1/5/15, at 6:20 p.m. in the third floor dining room temperatures of the residents' food were taken by a dietary aide (DA)-G at the request of the surveyor. The fish patties, pureed food and mechanical soft food registered 100 degrees and the water holding the food containers registered 90 degrees. These temperatures were verified by DA-G. DA-G stated, "I was going to give the next resident the fish patty because he is mechanical soft level 3." DA-G also stated he had just served a mechanical soft diet for a room tray at approximately 6:15 p.m. DA-G reported he had left the food covers off of the food Cambro serving unit throughout the entire service, said the food should have been held at 160 degrees. At 6:24 p.m. the certified dietary manager (CDM) explained that the third floor dining service was different from the other floors. Cambro insulated containers were utilized to serve the residents' food, and on first and second floors steam tables were used. The CDM also stated the water holding the food should be at 180 degrees and	21025	See Federal POC	

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the food temperatures needed to be held at 160 degrees. The CDM manager further stated it took a full hour to serve food on third floor.

On 1/6/15, at 9:04 a.m. in the third floor dining room covers were observed on the containers (Cambro, insulated) holding food waiting to be served. Upon request, DA-C took food temperatures. The water registered 120 degrees, hot cereal 120 degrees, scrambled eggs 110 degrees and oatmeal 130 degrees. DA-C said she had started serving breakfast at 7:30 a.m. and approximately twelve residents from the third floor had yet to be served breakfast as it was an open breakfast until 9:30 a.m. At 9:05 a.m. the CDM explained third floor served an open breakfast for two hours and foods should have been kept warm and maintained at 160 degrees plus. At 9:06 a.m. DA-C stated, "The eggs, oatmeal and hot cereal are already cold and I will have to heat this food up in the microwave." At 9:15 a.m. the CDM stated, "I am getting a couple of quotes on purchasing a new steam table."

On 1/6/15, at 10:33 a.m. R137 was asked standardized interview questions regarding whether the food tasted good and looked appetizing. R137 replied, "The fish is half cooked, the fish is not done." As far as whether food was served at the proper temperature R137 answered, "The fish is cold as hell." R137 resided on the third floor, and his quarterly Minimum Data Set dated 10/21/14, indicated he had moderately impaired cognition.

On 1/6/15, at 12:25 p.m. in the third floor dining room DA-C upon request took the temperatures of the food served from Cambro containers. DA-C measured the temperatures of the food. The mashed potatoes measured 110 degrees,

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ground ham 96 degrees, peas 80 degrees and steak patties were 80 degrees. DA-C was just about to serve R6 the steak patty, and R22 ground ham, peas and mashed potatoes when the surveyor intervened. DA-C verified R6 and R22's food was cold and reheated the food in the microwave. At 12:38 p.m. the CDM stated he would have expected the residents received food warm enough, and said residents could request food be warmed in the microwave.

On 1/7/15, at 9:27 a.m. in the third floor dining room DA-C was about to serve R64 her breakfast when surveyor observed no visible steam coming up from the oatmeal. DA-C upon request took the breakfast food temperatures. Pureed eggs, scrambled eggs, and pureed bread all registered 110 degrees and oatmeal 140 degrees. The surveyor then tasted all the foods served and found they were not warm, nor palatable. DA-C stated R64 was a "feeder" and said "feeders are served last" because they did not want the food sitting in front of them as it would get cold while they waited for assistance to eat. DA-C stated she would reheat R64's food before serving. A nursing assistant (NA)-D stated she would reheat R163's scrambled eggs, oatmeal, and toast in the microwave because the food was cold. NA-D said R12 was a "feeder" as well, and she would reheat her scrambled eggs, toast and oatmeal. NA-G reheated R33's scrambled eggs, oatmeal and toast. At 9:43 a.m. DA-C had R64's breakfast reheated in the microwave as it was not warm enough to be served. At 9:44 a.m. R47's scrambled eggs, oatmeal and pureed bread was reheated in the microwave by NA-G and NA-G reported R47 was a "feeder." At 9:47 a.m. DA-C stated she was finished serving breakfast and said breakfast service usually went past 9:30 a.m. DA-C also stated R6 and R22 received room

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21025	Continued From page 17 trays at approximately 9:00 a.m. On 1/8/15, at 9:14 a.m. DA-D stated there were five residents yet to eat breakfast on the third floor. Upon request DA-D checked the food temperatures in the steam table. DA-D verified the pureed egg temperature registered 135 degrees, pureed toast 140 degrees, and the oatmeal 140 degrees. On 1/9/15, at 9:20 a.m. DA-E stated, "This steam table is better than the Cambro." DA-E reported eight residents had not yet been served breakfast. Upon request DA-E checked the temperature of the food in the steam table. DA-E was provided instruction to ensure the thermometer did not touch the bottom or sides of the metal pan, and instead to ensure it was toward the middle of the food being tested. The Cream of Wheat measured 110 degrees, pureed eggs 128 degrees, pureed toast 140 degrees, oatmeal 145 degrees, and scrambled eggs 150 degrees. DA-E also reported, "The temperatures were 180 and 160 degrees when I started this morning." The bottom of the pans of food were not be touching the water, and only approximately 3/8 inches of water was in the bottom of the steam table. DA-E verified the pans of food were not touching the water. DA-E said she did not know how much water should have been in the steam table. She said she obtained the hot water from the unit sink, "but not too hot." DA-E stated she had two residents' mechanical soft diets to yet serve as well as R47 who was prescribed a pureed diet. DA-E stated she pulled back the plastic wrap and foil off the pans, and did not replace the covers on the pans during the food service period. DA-E explained, "I only have one cover and I do not use it to cover any food." At 9:34 a.m. DA-E checked the temperature of the	21025		

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21025	Continued From page 18 water and it registered 120 degrees. On 1/9/15, at 10:20 a.m. the CDM stated the bottom of the pans of food for service should have been covered by at least an inch of water and that the serving pans. In addition, pans should have been left covered when food was not being served. The CDM added, "I have to buy some new covers as we need more." The facility provided a 6/05 Food Temperature, Dietary Resource Manual. Under directions it read, "The following are suggested BEST PRACTICE temperature guidelines and do vary according to individual food item and resident preference. GOAL TEMPERATURES Hot Items Prior to Serving equal to or greater than 160 degrees, Point of Dining equal to or greater than 140 degrees. *Regulation requires hot food to be held at equal to or greater than 140 degrees. Although there is no stated temperature for serving in Federal Regulations, it is stated that food must be palatable and appropriate in temperature per resident preference. Adjust serving temperature upward for satellite service to assure adequate temperature at point of dining." SUGGESTED METHOD OF CORRECTION: The registered dietitian or designee could develop and implement policies and procedures to ensure food is held at the proper temperature in steam tables in the third floor dining room, and educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the quailtiy committee. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21025		

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21325	Continued From page 19	21325		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure follow up when a dental problem was identified for 1 of 3 residents (R20) reviewed for dental needs. Findings include: R20 was interviewed on 1/7/15, at 10:57 a.m. at which time the resident acknowledged and showed the surveyor she was missing many lower teeth and had no upper teeth. R20 stated she had an "upper plate" but did not wear it, instead kept it "in a drawer somewhere." When asked why the dentures were not worn R20 replied, "Because it hurts." R20 was unsure if facility staff knew about the ill-fitting dentures. The Admission Record indicated R20 was admitted in 10/14. A Care Area Assessment dated 11/5/14, revealed dental problem described as "broken or loosely fitting full or partial denture" and noted the resident was at risk for nutritional	21325	See Federal POC	2/10/15

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problems. Although the staff did not plan to address the dental issue on the care plan, it was noted a referral would be made to "onsite dental." However, R20's medical record lacked evidence the referral was completed.

R20's care plan dated 11/12/14, identified potential problem with nutritional status. Among the interventions was to observe for changes in chewing and eating abilities. The care plan did not address R20's dental problem.

On 1/7/15, at 11:59 a.m. a licensed practical nurse(LPN)-E stated he had observed R20's many missing teeth. However, LPN-E verified a care plan had not been developed regarding the issue, nor had a referral been made to the dentist. LPN-E stated he would call R20's family to check if they would consent to a dental visit.

On 1/8/15, at 11:15 a.m. R20's daughter, FM-B stated the facility had never consulted her regarding dental care for R20. FM-B was unaware of any care plan interventions regarding R20's dental status.

On 1/9/15, at 10:33 a.m. the director of nursing stated she expected staff nurses to follow up on problems identified during the comprehensive assessment, then develop a care plan and implement interventions according to that plan.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could develop and implement policies and procedures to ensure appropriate dental care is sought for residents who present with dental problems. Monitoring systems could be developed to ensure ongoing compliance and report the findings to the quality committee.

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21325	Continued From page 21 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21325		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene was implemented for 1 of 6 (R108) whose personal cares were observed. Findings include: R108 was provided morning cares by two nursing assistants (NA)-I and NA-H on 1/6/15, at 9:42 a.m. NA-I and NA-H donned gloves and checked R108's incontinent pad while the resident was lying in bed. Both NA-I and NA-H felt the inside of the incontinent pad and reported R108 did not need to be changed. NA-I and NA-H proceeded to transfer the resident using a mechanical lift into a tilt chair. Both NAs participated in providing cares including washing the resident's chest, underarms, arms, legs and peri area with a warm soapy wash cloth. Oral cares were then provided without glove changing and hand washing. When cares were completed, both NA-I and NA-H left R108's wearing the same soiled gloves. NA-I was observed to proceeded to the clean	21375	See Federal POC	2/15/15

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linen closet where she removed a clean towel and returned to R108's room. NA-I wet the towel with warm water and was about to wash R108's face when the surveyor intervened. NA-I verified she had not removed her gloves or washed her hands at appropriate times during personal cares for R108.

NA-H was observed walking down the hallway toward the dining area. NA-H removed her gloves, but did not perform hand washing. NA-H proceeded to the dining room and the surveyor intervened to stop NA-H before she began assisting a resident with eating. NA-H verified she had not removed her gloves or washed her hands at appropriate times during and following personal cares for R108.

On 1/8/15, at 2:54 p.m. a licensed practical nurse (LPN)-B stated she expected staff to perform hand washing before and after personal cares and before meal services.

The facility's 2013 Standard Precautions infection control policy specified "hand washing with plain or anti-microbial soap and gloves are to be removed between resident contacts, before touching uncontaminated surfaces or other areas of the same resident's body that may be uncontaminated. The purposed is to reduce the possibility that personnel will become transiently colonized with microorganism that can be transmitted to other residents."

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) and infection control nurse could develop and implement policies and procedures to ensure appropriate hand washing and glove use is used. All staff could be educated, and return demonstrations

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21375	Continued From page 23 observed. Monitoring systems could be developed to ensure ongoing compliance and report the findings to the quality committee. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21375		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate	21530		2/10/15

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21530	Continued From page 24 justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the pharmacist identified medication irregularities related in appropriate diagnosis and monitoring of antipsychotic medication for 1 of 5 residents (R76) reviewed for unnecessary medication use. Findings include: A consultant pharmacist reviewed R76's medications on 10/8/14. No irregularities were identified. It was noted the antipsychotic Seroquel had been discontinued and Zyprexa had been started for unspecified "delusions." R76 had diagnoses according to the resident's face sheet including dementia with behavioral disturbances, depressive disorder with recurring episodes, anxiety, and other persistent mental disorder due to conditions classified elsewhere. R76's 1/15 physician orders included Zyprexa 2.5 milligrams (mg) every 12 hours and 5 mg at bedtime for "for dementia", Remeron 45 mg for depression, and clonazepam 0.5 mg twice daily for anxiety. In addition, R76 also had multiple scheduled medications for constipation. A nursing order directed staff to monitor R76's	21530	See Federal POC	

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anxiety level, perseverating on bowels, presence/absence of bowel movements, and secluding self in room were to be monitored, but was not associated with a particular medication. For antidepressant use, staff were directed to monitor mood problems such as sad, withdrawn and mood changes, as well as several side effects including stiff neck, tremors, confusion, etc.

LPN-D said on 1/9/15, at 12:35 p.m. regarding evidence of identification and monitoring of target behaviors related to the use of the Zyprexa, she thought it would be found on the Treatment Administration Record (TAR). LPN-D was only able to locate information regarding the antidepressant medication, Remeron. LPN-D asked, Could you put Zyprexa in the same category with Remeron?"

LPN-E stated on 1/9/15, at 1:45 p.m. R76's TAR should have included specific behaviors/delusions the staff were to monitor, but was not being monitored. In addition, orthostatic blood pressures (blood pressure readings taken lying, sitting and standing after a period of rest that may have indicated a sudden drop in readings) should have been taken since the resident had been prescribed an antipsychotic medication. LPN-E stated, "I don't see any on his orders, but I will add them."

The director of nursing was interviewed on 1/91/5, at 1:50 p.m. and stated she would have expected target behavior monitoring when antipsychotic medication was used, as well as appropriate side effect monitoring, including orthostatic blood pressures.

During a telephone interview on 1/9/14, at 2:03

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21530	Continued From page 26 p.m. the consulting pharmacist (CP)-A stated, "I would expect 'delusional disorder' as an indication" for antipsychotic use. In addition, he would expect staff to have identified and monitored target behavior and medication side effects. SUGGESTED METHOD OF CORRECTION: The pharmacist with the director of nursing (DON) could develop and policies and procedures to ensure medications are appropriately monitored. Audits could be implemented to ensure ongoing compliance and report the findings to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the	21535		2/10/15

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 27 Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a rationale for the continued use of antipsychotic medication in absence of an appropriate diagnosis, as well as identification and target behavior monitoring for 1 of 5 residents (R76) reviewed for unnecessary medication. Findings include: R76 was observed resting in his room on 1/7/15 at 11:15 a.m. and again at 1:25 p.m. He answered a few questions posed to him in a quiet, slightly mumbling voice with his eyes sometimes closed. He reported he "could be better," and when asked to elaborate said he felt nauseated. The following day at 9:19 a.m. R76 was again lying in bed, and he in a soft spoken voice reported not feeling well, but was unable to pinpoint why. R76 had diagnoses according to the resident's face sheet including dementia with behavioral disturbances, depressive disorder with recurring episodes, anxiety, and other persistent mental disorder due to conditions classified elsewhere. R76's Minimum Data Set (MDS) dated 9/24/14 revealed the resident had moderately impaired cognition. Mood and behavioral issues were not	21535	See Federal POC	

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identified. In a subsequent quarterly MDS (dated 12/23/14), although the resident continued to have moderately impaired cognition, his score went from the high end of 11, to the low end of eight or one point from severe cognition. Behavioral issues were again not identified, but the addition of the presence of multiple mood indicators were. These included little interest, feeling down, sleeping too much or too little, little energy, and trouble concentrating.

A consultant pharmacist reviewed R76's medications on 10/8/14. No irregularities were identified. It was noted the antipsychotic Seroquel had been discontinued and Zyprexa had been started for unspecified "delusions."

R76's 1/15 physician orders included Zyprexa 2.5 milligrams (mg) every 12 hours and 5 mg at bedtime for "for dementia", Remeron 45 mg for depression, and clonazepam 0.5 mg twice daily for anxiety. In addition, R76 also had multiple scheduled medications for constipation. A nursing order directed staff to monitor R76's anxiety level, perseverating on bowels, presence/absence of bowel movements, and secluding self in room were to be monitored, but was not associated with a particular medication. For antidepressant use, staff were directed to monitor mood problems such as sad, withdrawn and mood changes, as well as several side effects including stiff neck, tremors, confusion, etc.

A licensed practical nurse (LPN)-D indicated on 1/8/15, at 9:29 a.m. that R76 perseverated on bowel movements. He reported constipation when he was actually not and thought Milk of Magnesia (for constipation) "is a magic solution." LPN-D explained R76 had not been eating well

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for a while, but since an increase in his Zyprexa (antipsychotic) and Klonopin (anti-convulsant commonly used for anxiety) he had been eating better and a slight improvement was noted in his mood. LPN-D said staff re-directed the resident when he perseverated to a topic such as sports and therapeutic recreation staff took him to down to the facility store. R76 could become very anxious about what was served at mealtime, and "If there's no prune juice, we'll run down and get it for him." The staff had implemented a system with the physician of validating his bowel movements via a log on the bathroom wall, "but that didn't work for him."

On 1/8/15, at 10:32 a.m. LPN-E indicated some changes in R76's medication had been tried. "He had used to do better so we cut some meds [medications] a little. He declined more and so we increased some meds back toward how it was before to optimize [his treatment]." LPN-E described the resident as being very complex and was "pretty conscious of not being well." Most recently his psychotropic medications were increased and other general medications were decreased.

LPN-D said on 1/9/15, at 12:35 p.m. R76 had remained about the same regarding his anxiety and seclusion, and said the behaviors varied from day to day and/or at different times of the day. When asked for evidence of identification and monitoring of target behaviors related to the use of the Zyprexa, LPN-D said she thought it would be on the Treatment Administration Record (TAR). LPN-D was only able to locate information regarding the antidepressant medication, Remeron. LPN-D asked, Could you put Zyprexa in the same category with Remeron?"

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21535	Continued From page 30 During an interview on 1/9/15, at 1:31 p.m. a housekeeper (H-B) reported R76 was in his room sleeping most of the time. On 1/9/15, at 1:39 p.m. LPN-D verified R76 experienced a fall on 12/30/14, and explained his gait was unsteady and he had tripped over another resident's walker. On 1/9/15 at 1:44 p.m. a nursing assistant (NA)-F reported R76 was shaky, which had improved some than when he first came to the unit. She had noticed increased confusion. LPN-E stated on 1/9/15, at 1:45 p.m. R76's TAR should have included specific behaviors/delusions the staff were to monitor, but was not being monitored. In addition, orthostatic blood pressures (blood pressure readings taken lying, sitting and standing after a period of rest that may have indicated a sudden drop in readings) should have been taken since the resident had been prescribed an antipsychotic medication. LPN-E stated, "I don't see any on his orders, but I will add them." The director of nursing was interviewed on 1/91/5, at 1:50 p.m. and stated she would have expected target behavior monitoring when antipsychotic medication was used, as well as appropriate side effect monitoring, including orthostatic blood pressures. During a telephone interview on 1/9/14, at 2:03 p.m. the consulting pharmacist (CP)-A stated, "I would expect 'delusional disorder' as an indication" for antipsychotic use. In addition, he would expect staff to have identified and monitored target behavior and medication side effects.	21535		

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21535	Continued From page 31 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), medical director, and pharmacist could develop and policies and procedures to ensure medications are appropriately prescribed and monitoring being completed. Appropriate staff could be eeducated. Monitoring systems could be implemented to ensure ongoing compliance and report the findings to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adequate housekeeping and maintenance throughout the building, potentially affecting all 101 residents residing in the facility and and visitors. Findings include: A housekeeper (H)-B was interviewed on 1/8/15, at 9:10 a.m. She reported third floor only had one housekeeper, "and that is too much for one person." H-B tried to help out when she finished the work on the floor where she worked, by emptying garbage on third floor.	21665	See Federal POC	2/13/15

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21665	Continued From page 32 R110 said in an interview on 1/8/15, at 1:56 that staffs' hours had been cut which in turn affected the cleanliness of building. When "the census drops the cleaning staff has to go home." In addition, she alleged one of the weekend staff called in on two different Sundays because she wanted to go to church. This left no cleaning staff on the floor where the resident resided. R110 felt the housekeeping staff also needed additional training. Some examples she cited included their responsibility for stripping beds. Pillows, blankets and bedspreads were piled up around the room, including on the soiled laundry bin. The previous day R110 had also observed a housekeeper leave a vacuum cleaner in the hallway and then went on to a new task. A short time later a maintenance staff person discovered and moved the vacuum cleaner. R110's Minimum Data Set assessment dated 11/1/14, noted the resident was cognitively intact. During the environmental tour on 1/8/15, at 2:00 p.m. the administrator reported the facility had not been utilizing a preventive maintenance plan. They had just hired a new director of environmental services (DES) who had already identified numerous maintenance and housekeeping issues. The DES said the only preventive maintenance that he could see was related to major equipment, such as air handling, mechanical lifts, etc. Maintenance issues were otherwise written on a clipboard or were reported in stand-up meetings. The administrator said previously the need for painting was not noted by the DES or painters were called in at $40 an hour. There had been no systematic method of ensuring maintenance issues were addressed, such as painting. Going forward, new expectations had been laid out for the DES who was newly hired.	21665		

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21665	Continued From page 33 Overall the walls and floors on the third floor were not cleaned and/or maintained. Wall paper in the hallway had numerous gouges and scrapes. The carpeting was worn near the elevators and nursing stations. Carpeting was stained and/or soiled at the elevator area and in areas near the drinking fountain. Linoleum in resident rooms was not cleaned at the edges and dust and debris was noted in the corners of the rooms as well as small nicks and holes in linoleum. Baseboards were loose particularly at edges and were pulled away from the walls. A cover outlet in room 304 was loose from the wall, and an area on the walls had been patched but was not repainted. In room 312 and 316 the doorway protective plastic was pulled away from the doors. The draft sheet inside the doorway of room 316 was pulled loose along the length of the door. The electrical box in room 321 had pulled away from the wall and was hanging loose. The DES explained that some of the beds had caught on the boxes on the wall when the beds were lowered or raised. Ventilation appeared to be working in the 3 north bathroom, however, a stale odor was detected and a the ceiling vent was covered with a heavy buildup of dust. The first floor main entryway had a large amount of salt and sand on the hallway linoleum, entry rugs, and near the elevator area at various times of the day. The DES said it required frequently cleaning due to the heavy traffic from the outside. The grooves in the elevator threshold had a heavy build-up of dirt and debris. Although hand rails throughout the building were without splinters, the finishes appeared worn. The administrator said she had been informed there were plans to have the rails replaced. In	21665		

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addition, the administrator reported she had been informed the owners had planned to appropriate a large amount of money toward building upgrades, but she had not yet been told any specific information regarding the plan.

During the tour of the laundry area on 1/9/15, at approximately 8:20 a.m. with the DES, the following was noted: The door to the entrance of the laundry room had a large gouge and was heavily nicked. Loose tiles were noted on the walls, and a heavy build-up of dust was observed through the area. Three dryers had a heavy build-up of lint on the removable lint vent screens. Inside the soiled utility room four ceiling tiles hung sideways down from the ceiling. A heavy build of dust was noted on the cords connected to the lighting and on top ledges around the entire utility room. The employee hand washing sink had a heavy thick, dark build-up on the bottom and sides of the sink that appeared to be dried paint. A high pile of trash bags containing discarded clothing was stored on the top of a personal-type washing machine. The inside of the machine contained a bucket of an unknown liquid chemical. Paint on the walls throughout the room where wash barrels were stored was peeled and chipped from the floor to approximately 5-6 feet.

On 1/9/15, at 10:17 a.m. the laundry area was observed with the administrator. The administrator reported the DES was responsible for deep cleaning and maintenance of the laundry area. The peeled paint had been caused by the use of high pressure hoses.

The DES reported on 1/9/15, at 11:35 a.m. the facility did not employ a separate housekeeping and laundry supervisor, and was also his responsibility. He stated that "near as I can tell"

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housekeeping staffing was at four staff for 6.5 hours a day--one housekeeper for each floor and an additional staff for maintaining common areas such as the entryway, shoveling, emptying garbage, etc. On weekends, it appeared there were two housekeepers who worked 6.5 hours a day. The previous DES reportedly hired a new housekeeper just prior to his resignation, however, that person never showed up for work. It was unknown if someone had actually been hired as was reported. The DES was unaware of problems with staff not showing up on weekends, but said he was still trying to figure out the system that had been previously used. Plans were in place to immediately replace the electrical box in room 321.

During an environmental tour on 1/8/15, at 2:00 p.m. the administrator explained that staff had discovered one of the two locked doors to the memory care unit was not functioning. properly when the keypad was loose. In addition, some call lights were also not working. The administrator said the issue with the call lights may have been reported by surveyors and was thought could have been related to the issue with the security door. An outside repair company was called and completed the necessary repairs. Additionally, six new call lights were ordered.

On 1/9/15, at approximately 4:30 p.m. the administrator said that after the previous DES recently left employment all policies related to maintenance appeared to be missing.

SUGGESTED METHOD OF CORRECTION:
The director of maintenance or designee could develop and implement a preventive maintenance plan. A system for reporting necessary repairs in the building could be instituted and all staff

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21665	Continued From page 36 educated. Audits could be conducted and the results reported to the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21665		
21670	MN Rule 4658.1405 A.B.C.D. Resident Units The following items must be provided for each resident: A. A bed of proper size and height for the convenience of the resident, a clean, comfortable mattress, and clean bedding, appropriate for the weather and resident's comfort, that are in good condition. Each bed must have a clean bedspread. A moisture-proof mattress or mattress cover must be provided for all residents confined to bed and for other beds as necessary. Rollaway type beds, cots, or folding beds must not be used. B. A chair or place for the resident to sit other than the bed. C. A place adjacent or near the bed to store personal possessions, such as a bedside table with a drawer. D. Clean bath linens provided daily or more often as needed. E. A bed light conveniently located and of an intensity to meet the needs of the resident while in bed or in an adjacent chair This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure linens were in good repair and an adequate supply was available in 5 of 6 linen closets and to ensure bed	21670	See Federal POC	2/13/15

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21670	Continued From page 37 linens were routinely changed. Findings include: On 1/5/15, at 11:43 a.m. while completing an initial tour of the facility, resident beds in rooms 321, 322 and 326 were striped clean of any bed linens. Pillows, blankets and bedspreads were piled in the middle of the beds. On 1/5/15, at 4:02 p.m. R64's fitted sheet on his bed was observed to be very thin appearing with approximately eight quarter inch holes along the side of the fitted sheet. On 1/6/15, at 12:54 p.m. R105's fitted sheet of his bed was observed to very thin appearing and many small holes along the side of the fitted sheet. A housekeeper (H)-B was asked about the facility's system for stripping beds on 1/8/15, at 9:10 a.m. H-B reported the housekeepers were responsible for stripping beds according to a list. When asked where the list was kept H-B responded, "I think" there was one in the soiled utility room. She then brought the surveyor to the utility room where a posted listing showed three or more room numbers for different days of the week. H-B said she stripped and then washed the beds if needed, and then the NAs were supposed to remake the beds. When she found sheets that were thin and worn and/or had holes she threw them away. R110 expressed concerns with the facility's system for linen changes on 1/8/15, at 1:56 p.m. She reported she did not like the manner in which beds were stripped and explained that the housekeeper stripped the bed stacking the	21670		

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pillows and bedspread on the soiled laundry bin and chairs in the room. The nursing assistants (NAs) made the bed when they had time. "It irritates me. I don't like it at all." R110 felt it would have been more appropriate to have the NA strip and then make the bed, because they did not necessarily have time to make the beds at the time they were stripped, therefore the bed remained unmade and residents could not lie down as they wished. In addition R110 stated, "In the last year I don't know what happened to the wash rags...In the evening or late afternoon there aren't any," and described the facility as being "dangerously low on them."

The DON reported on 1/8/15, at 2:25 p.m. she believed linens were changed on bath days. A licensed practical nurse (LPN)-D informed the DON at 2:39 p.m. that the facility "used to have bed makers." The DON then asked a registered nurse (RN)-A at 2:40 p.m. about the facility's system for changing bed linens. RN-A reported bed linens were changed "when obviously soiled." The DON then stated, "On bath days," to which RN-A replied they "do it with the bath-type thing." When the surveyor asked for clarification RN-A stated bed linens were changed "when they are soiled." At 2:44 a health unit coordinator (HUC)-A was asked by the DON if she knew the facility's system for stripping bed linens. HUC-A said she believed "laundry strips so many beds each day," and said there used to be a list of those rooms in the linen closets. The DON looked in the linen closet, but was unable to locate the list. The surveyor then showed her the list in the soiled utility room. The DON responded, "Looks like we need to work on that system too. That's not good." The DON had not heard of a linen issue, but was aware there had been a problem at times with staff throwing the wash cloths away with the

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21670	Continued From page 39 soiled linen. Observations of the six linen closets on the three floors were then conducted with the DON and linen was available/unavailable as follows: 1) 1 north closet contained no wash cloths, no hand or bath towels, two pillow cases, one gown, four blankets, no bedspreads, and one sheet; 2) 1 south closet was the most fully stocked of all six closets and included a stack of approximately 30-35 wash cloths and a supply of bath towels and sheets, one gown, two pillow cases, and no hand towels. The DON said she was unsure whether hand towels were usually available or only bath towels; 3) 2 north closet contained no wash cloths, no hand or bath towels, no gowns, no bedspreads, five sheets, three pillow cases; 4) 2 south closet one wash cloth, bath towels but no hand towels; 5) 3 north closet contained one sheet and three blankets, but no other linen; 6) 3 south closet one wash cloth, bath towels but no hand towels. On 1/8/15, at 1:35 p.m. R105's bed remained stripped of linen and the bedspread, blanket, and pillow were piled at the end of the bed. There was a spill of water pooled on the end of the mattress near the piled linens. No staff could be found in the area. A licensed practical nurse (LPN)-C who worked on the other end of the floor was asked to assist R105. She was unsure how the water got onto the mattress.	21670		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21670	Continued From page 40 On 1/9/15, at 10:17 a.m. a housekeeper (H)-C reported there was no set times for picking up linens, and the last time he had picked up linens for washing was at approximately 9:00 a.m. At 10:43 a.m. HK-C was observed delivering clean linen to the third floor linen closet. When the linen closet was opened, it contained only 10 bath blankets. Washcloths, towels, and other bedding had been unavailable prior to the delivery. Policies regarding linen handling and bed stripping were requested on 1/9/15, but were not provided. SUGGESTED METHOD OF CORRECTION: The director of housekeeping and laundry could develop and implement policies and procedures to ensure linens are in good repair and in adequate. Audits could be conducted at various times of the day and the results of those audits could be brought to the quality committee for their review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21670		
21705	MN Rule 4658.1415 Subp. 6 Plant Housekeeping, Operation, & Maintenance Subp. 6. Heating, air conditioning, and ventilation. A nursing home must operate and maintain the mechanical systems to provide comfortable and safe temperatures, air changes, and humidity levels. Temperatures in all resident areas must be maintained according to items A to C: A. For construction of a new physical plant, a nursing home must maintain a temperature range	21705		2/13/15

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21705	Continued From page 41 of 71 degrees Fahrenheit to 81 degrees Fahrenheit at all times. B. For existing facilities, a nursing home must maintain a minimum temperature of 71 degrees Fahrenheit during the heating season. C. Variations of the temperatures required by items A and B are allowed if the variations are based on documented resident preferences. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident rooms were maintained at a comfortable temperatures in 4 of 33 rooms observed affecting five residents (R160, R106, R4, R54, R104) when either complaints were registered regarding and/or observations revealed cool temperatures. Findings include: An environmental tour was conducted with the administrator and the director of environmental services (DES) on 1/7/15, at 2:00 p.m. The outside temperature was below zero, and temperatures in resident rooms were taken when some of the residents complained they were cold. The maintenance director was in his first week of employment. He explained the facility's boiler system had a built-in windchill factor adjustment, but he had found it had not been set accordingly. All temperatures were taken at the floor level: 1) R160's room registered 66 degrees Fahrenheit (F). The DES reported a draft could be felt at the upper corner of the window. 2) R84's room registered 65 degrees F and the resident complained he felt cold. 3) R54 and R4's room registered 63 degrees. Both residents in the room complained of being cold. R54 stated, "It's cold in here! I'm cold!" R4 said he had resided in the	21705	See Federal POC	

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21705	Continued From page 42	21705		

room for some time and it had always been "the coldest room in the building." The DES, administrator, and surveyor all agreed the room felt chilly. The DES explained that each resident room had an individual thermostat. He made adjustments to each of the thermostats in the rooms that were checked, and said there was still room to increase the temperature, but perhaps staff were not making the appropriate adjustments when complaints were voiced regarding room temperatures.

R104's family member (FM)-C approached the nursing desk on 1/8/15, at 11:21 a.m. and stated emphatically to a registered nurse (RN)-A and the surveyor, "I want you both to come back to my mother's room and see how cold it is! See if you think you would want your 90 year old mother to be in a room that cold!" RN-A and the surveyor then both observed the room and agreed it felt chilly. RN-A adjusted two thermostats in the room. RN-A then notified the DES the problem, and requested he return to the room in two hours to ensure the room temperature was comfortable. RN-A then informed the surveyor that residents, family members, and staff may not have known how to check the room temperatures or make adjustments to thermostats for residents' comfort.

The administrator reported at the start of the environmental tour that the facility had not been utilizing a preventive maintenance plan. On 1/8/15, at approximately 4:30 p.m. the administrator said that after the previous DES recently left employment all policies related to maintenance appeared to be missing.

SUGGESTED METHOD OF CORRECTION: The maintenance director or designee could develop and implement policies and procedures

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21705	Continued From page 43 to ensure resident rooms are maintained at a comfortable temperatures; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21705		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data	21800		2/10/15

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21800	Continued From page 44 Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure appropriate notice of the right to request a demand bill when Medicare was discontinued was provided as required for 2 of 3 residents (R56, R40) reviewed for liability notice. Findings include: R56 was admitted to the facility on 6/4/14, after a qualifying hospitalization and required rehabilitation therapy. R56 was discharged from Medicare non-coverage on 7/24/14, and was discharged from the facility on 7/25/14. On 7/14/14, at 3:24 p.m. a nursing note indicated that R56 was asked to sign a Medicare denial notice. The note indicated the resident refused to sign the notice, stating her son signed everything on her behalf. A telephone message was left for R56's son. Nursing notes did not reflect further attempts made to contact R56's son for a signature on the denial notice. According to a CMS 10123 form, R56's services ended on 7/24/14, and it was noted R56 refused to sign the form. The form did not indicate whether R56's son was informed services would be ending, since R56 had previously reported her son signed all paperwork on her behalf. On 1/9/15, at 2:44 p.m. the health information manager (HIM) explained that R56's services ended on 7/24/14. The CMS 10123 form for R56	21800	See Federal POC	

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21800	Continued From page 45 was reviewed and a Post-it note was attached that read, "refused to sign." The form lacked documentation showing R56 had been provided a 48-hour notice as required before Medicare non-coverage date. R40's Medicare part A services ended on 9/12/14, and the resident was discharged from the facility on 9/13/14, according to an interview with the HIM on 1/9/14, at 4:19 p.m. On 1/9/15, at 4:19 p.m. the HIM explained that R40 had not been provided a denial notice, as the resident requested to be discharged on 9/13/14, before her coverage would have ended. On 1/9/15, the Minimum Data Set Medicare coordinator explained there was no other available documentation available related to liability notices for R56 or R40. A policy on liability notices was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The business office manager or designee could ensure policies were developed related to Medicare denial and appeal rights notices. Appropriate staff could be educated. Audits could be conducted to ensure ongoing compliance and the results reported to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21800		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights	21810		2/10/15

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21810	Continued From page 46 Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility did not ensure a specialized call light was provided for 1 of 1 resident (R163) who was unable to use a standard call light. Findings include: R163 was observed while lying in bed on 1/8/15, at 11:25 a.m. a ball shaped call light was attached to left side head of the bed. When asked if he could use the call light, R163 lifted up his hand and bent his fingers attempting to grasp the ball shaped call light and shook his head back and forth voicing "no" he was unable to activate the call light. Admission Minimum Data Set (MDS) dated 12/24/14, indicated R163 was moderately cognitively impaired, had a diagnosis of cancer, and required extensive staff assistance with cares. On 1/8/15, at 11:35 a.m. a licensed practical nurse (LPN)-B stated, "I brought in a specialized pancake flat call light in for [R163] yesterday." LPN-B also stated she had asked R163 to show if he could use the pancake like call light and R163	21810	See Federal POC	

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21810	Continued From page 47 was able to put his hand on the flat call light and activate it. On 1/9/15, at 9:45 a.m. R163's call light was inaccessible. R163 was lying in bed with a flat shaped call light attached snuggly in between the outside of the mattress and the left quarter side rail. Following the observation at 9:49 a.m. LPN-F verified the resident would not have been able to access the light. LPN-F stated, "This flat call light is more sensitive than the standard push button call light. The flat call light should be placed somewhere here" and LPN-F pointed toward the top of R163's abdomen. LPN-F then placed the flat call light on R163's abdomen and near R163's hand and instructed R163 regarding the call light placement and R163 lifted up his hand and placed on flat call light and activated call light. Nursing assistant (NA)-B was asked on 1/9/15, at 9:50 a.m. about differences between standard and specialized call lights. The NA was unaware of any differences in call lights. At 9:55 a.m. LPN-F explained when R163 came in to the facility he was much stronger and was able to utilize a standard push button call light, but now could not. At 10:01 a.m. LPN-G stated, "I knew [R163] could not push the standard push button call light, so I called physical therapy and told them. That is when the ball shaped call light for him [R163] was put in." A 12/18/14, hospice visit summary note, "Recommended [R163] had a pancake call light as he was too weak for a standard call light."	21810		

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21810	Continued From page 48 A nursing progress note dated 12/23/14, read "Resident [R163] reported to writer that he does not use call light" because it was hard to press the button. "Maintenance was left a voice message with requests for pad call light. Request was also placed on maintenance clip board." A nursing progress note dated 1/7/15, read "Resident [R163] bed was changed and a flat (pancake-like) call light ordered." The care plan also dated 1/7/15, indicated R163 was to have a pancake call light. On 1/9/15, at 10:56 a.m. the director of nursing stated she expected residents' call lights to be within their reach and she also expected staff to follow residents' care plans. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents who are unable to use standard call lights receive specialized call lights whose designs are tailored to an individual's needs; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the quality committee. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21810		
21870	MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests.	21870		2/13/15

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21870	Continued From page 49 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a formalized system to ensure residents and families were encouraged to bring up concerns and those concerns were tracked and received follow-up. This had the potential for affecting those residents or their representatives who may have wished to voice a grievance. Findings include: The director of nursing was interviewed regarding the facility's grievance system on 1/7/15, at 10:35 a.m. She stated she was unaware of a facility system of tracking concerns. On 1/8/15, at 2:20 p.m. the DON stated concern forms had recently been made available after an observation was made that completed forms were not being received. It was discovered the forms had not been made available for "quite a while--possibly months." The DON said an "education piece" was needed regarding concerns, including what needed to be completed related to the concerns, etc. She was unaware whether the facility had solicited information from residents and families, such as via satisfaction surveys. Although the DON encouraged people to call her if they had concerns, said the system was "not as formalized as it needs to be." The quality manager was interviewed on 1/8/15, at 9:39 a.m. When asked how residents and families were encouraged to report concerns, she said they could tell the supervisor. Regarding anonymously reporting, the manager said the concern report could be given to a NA. When pointed out it would then not have been	21870	See Federal POC	

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21870	Continued From page 50	21870		

considered anonymous the manager said it was a "good question." She did not know of a place to drop off reports such as a suggestion box, but said it was a good idea.

A Concern and Problem Resolution Form supply and drop off box was observed adjacent to the first floor reception desk. The form read, "...We welcome your suggestions, comments, and/or concerns. This form may be used to provide the information regarding your suggestion/concern to us without fear of discrimination or reprisal. We will respect your confidentiality and provide you a follow-up response. Once you have completed this form, please give it to any of our Social Workers or department managers." The bottom of the form asked who had completed the form, etc. It did not indicate the drop off box could be used or that it was an option for complainants to remain anonymous (although follow-up with the complainant would then not have been possible). The back of the form detailed investigative and follow-up measures.

A licensed social worker (LSW)-A was interviewed on 1/9/15, at 1:20 p.m. regarding the facility's system for soliciting concerns from residents and families, and ensuring follow up to those concerns. LSW-A said both LSWs were new to the facility, and although they did not have a formalized system for tracking concerns and bringing them to the quality committee for review, they did note some concerns in residents' nursing notes. They also asked residents and families if they had concerns at quarterly resident care conferences. The residents had invited the LSWs to their resident council meeting, but then did not recall a specific reason they had been invited to attend. The LSWs asked the residents if they had concerns, but did not ask any specific probing

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21870	Continued From page 51 questions. Although resident rights were not covered in the meeting, they "reminded them of that." The facility had considered sending out satisfaction surveys "just to kind of track that on discharges." It was felt they would get more honesty if a resident was no longer living at the facility. LSW-A had heard some of the residents were a little afraid to complain, but the LSW tried to reassure them and to show follow up if they did report a concern. LSW-A said most of the concerns went to the DON and the LSWs received mostly missing property. "It's not a precise process right now" and staff was not tracking or following up on missing property. "With the whole reconstructing thing [new management staff] we are doing things the way they had it, and making the assumption it's getting done." The facility's 9/10 Concern or Problem Resolution Policy indicated residents, families, or other concerned individuals "may complete a Concern or Problem Resolution Form as a means of communicating their problems/and receiving follow-up from the facility...Grievances can be submitted to the social worker, Executive Director/Residence Director, or any manager/supervisor." SUGGESTED METHOD OFCORRECTION: The licensed social workers, adminstrator, and director of nursing (DON) or designee could develop and implement policies and procedures to ensure a system is in place that encourages residents and families to bring up concerns and those concerns are tracked and receive follow up; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the quaility committee.	21870		

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21870	Continued From page 52 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21870		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary	21880		2/10/15

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21880	Continued From page 53 treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure appropriate follow-up to resident concerns for 1 of 3 residents (R5) whose family member reported non-resolution to a reported missing item. Findings include: R5's family member (FM)-A was interviewed on 1/6/15, at 2:15 p.m. When asked if R5 had been missing any personal belongings, FM-A replied, "Yes." FM-A stated her mother's watch had been missing for a couple of months now. Although she had reported this to a licensed practical nurse (LPN)-B, the watch had not been found and no staff member followed-up regarding her reported concern. A follow-up interview was conducted with FM-A on 1/9/15, at 1:58 p.m. FM-A explained that during a care conference in 10/14, she reported R5's was missing a watch to LPN-B. FM-A stated that she was not given the option to fill out a missing items report or a grievance form. FM-A stated that the missing watch was never found and no one had ever followed up to let her know whether the watch had been found, "so I just gave up on it."	21880	See Federal POC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00255	A. BUILDING: _____ B. WING _____	01/09/2015

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21880	Continued From page 54 On 1/8/15, at approximately 12:15 p.m. the third floor nursing station missing items clip board was reviewed. Several items were listed on the board as "missing," however, several items were not dated indicating the item had been found. Following the review of the clip board, both LPN-A and a nursing assistant (NA)-C both said they would have reported a missing item to the supervisor. Neither LPN-A or NA-C were aware a resolution form should have been filled out, or that items were tracked using the missing items clip board. An activity staff (AS)-A was then interviewed and stated she was unaware of a report R5's watch had been missing. On 1/8/15, at 1:12 p.m. a licensed social worker (LSW)-A stated if a resident items were missing, staff were to fill out a resolution form, found at all nursing stations. The form was to then be submitted to a LSW who reviewed for form, and informed the resident's family, administrator, and director of nursing. LSW-A explained that other staff were made aware of the missing items via verbal communication and word of mouth. LSW-A was unaware of R5's missing watch, and could not find a resolution form regarding the watch. LSW-A said missing items were looked into for a week or two, and then the LSW would follow up. If the item was not found, the family was informed. Should the family chose to replace the item, the facility would reimburse them. On 1/8/15, at 2:54 p.m. LPN-B stated staff were notified of missing items via a progress note as well as on the missing item clip board located at the nursing station. LPN-B stated that staff persons were trained on the facility's system for reporting missing items from the LSWs. LPN-B	21880		

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21880	Continued From page 55 stated she was unaware R5's watch was missing. On 1/8/15, at 1:41 p.m. the director of nursing (DON) stated the steps for tracking a missing item was as follows: Once a concern form was filled out it was given to the LSW. The missing item was discussed at the nursing meeting and other staff was informed about the missing item through verbal communication from the nurse managers. The DON stated that the LSW was responsible for following up regarding missing items. On 1/9/15, at approximately 4:00 p.m. the infection control nurse stated she trained all newly hired staff as to how to report missing items and in filling out the concern forms. The facility's 2009 policy for Completing the Suggestion or Problem Resolution Form indicated concerns, "will be reviewed by the Executive Director and given to the appropriate department head. The person assigned to investigate and resolve the issue will complete the resolution form in the area, plan of resolution and follow-up comments after review with the concerned party. If the person is not satisfied with the resolution, they will contact the Executive Director, who will evaluate the outcome with the customer." SUGGESTED METHOD OF CORRECTION: The licensed social workers or designee could develop and implement policies and procedures to ensure that residents receive the required followup for missing personal items; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the quality coittee. TIME PERIOD FOR CORRECTION: Twenty-one	21880		

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21880	Continued From page 56 (21) days.	21880		