CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 9KQN

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PARTI	- TO BE COMP	LEIEDDYI	HE SIA	IE SURVET AGENCT	Facility ID: 00/54
MEDICARE/MEDICAID PROVIDER (L1) 245509 2.STATE VENDOR OR MEDICAID NO.	NO.	3. NAME AND AD (L3) ADAMS HE (L4) 810 WEST M	ALTH CARE C			4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW
(L2) 015540300		(L5) ADAMS, MI	N		(L6) 55909	5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF OW	NERSHIP	7. PROVIDER/SU	PPLIER CATEGO	RY	<u>02</u> (L7)	7. On-Site visit 9. Other
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint
6. Date of survey 07/08/2013	(L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS	·		
From (a):		A. In Complia			And/Or Approved Waivers Of The	e Following Requirements:
		1	Requirements		Technical Personnel	6. Scope of Services Limit
To (b):		Complian	nce Based On:		3. 24 Hour RN	7. Medical Director
12.Total Facility Beds	54 (L18)	1.	Acceptable POC		4. 7-Day RN (Rural SNF)	
13.Total Certified Beds	54 (L17)		mpliance with Progrents and/or Applied		5. Life Safety Code * Code: A *	9. Beds/Room (L12)
		1			A	
14. LTC CERTIFIED BED BREAKDOW	N				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
54						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICABL	E SHOW LTC CANCI	ELLATION DATE):		
Post Certification Revisit by r	eview of the fa	cility's plan of co	orrection, to ve	erify that	the facility has achieved and	I maintained compliance with Federal
						for skilled nursing facility beds.
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY A	APPROVAL Date:
Gary Nederhoff, Uni	t Supervisoi	09/09/	2013	(L19)	Colleen B. Leach, Pr	rogram Specialist 12/20/2013
PA	ART II - TO BE	COMPLETED	BY HCFA RI	EGIONAL	L OFFICE OR SINGLE STA	ATE AGENCY
19. DETERMINATION OF ELIGIBILITY	7		MPLIANCE WITH	CIVIL	21. 1. Statement of Finan- 2. Ownership/Control	cial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)
_X 1. Facility is Eligible to Pa	rticipate				3. Both of the Above	:
2. Facility is not Eligible	(L21)					
	(L21)					
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEM	IENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	Е	VOLUNTARY 00	INVOLUNTARY
01/01/1988					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	nt 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIV	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER
		of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
7.45			(L44)			00-Active
(L27)	B. Rescind Sus	pension Date:				
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/0	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	22	. DETERMINATION	OE APPROVAL D	ATE		
51. KO KECEH I OF CMS-1339	32	07/25/2013	OI AIIKUVAL D	AIE		
	(L32)	01/23/2013		(L33)	DETERMINATION APPRO	OVAL.



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5509

December 20, 2013

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

Dear Ms. Hinkle:

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

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

Effective June 12, 2013, the above facility is certified for:

54 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 54 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Colleen B. Leach, Program Specialist

Colleen Feach

Program Assurance Unit, Licensing and Certification Program

Division of Compliance Monitoring

Minnesota Department of Health

P.O. Box 64900, St. Paul, MN 55164-0900

Telephone #: (651)201-4117 Fax #: (651)215-9697

Licensing and Certification File cc:



Protecting, Maintaining and Improving the Health of Minnesotans

July 8, 2013

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

RE: Project Number S5509022

Dear Ms. Hinkle:

On June 5, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 22, 2013. 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 July 8, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 22, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 12, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 22, 2013, effective June 12, 2013 and therefore remedies outlined in our letter to you dated June 5, 2013, will not be imposed.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Program Specialist Program Assurance Unit Licensing and Certification Program **Division of Compliance Monitoring** P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5509r13.rtf

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245509	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 7/8/2013
Name of Facility			Street Address, City, State, Zip Code	
ADAMS HEALTH CARE CENTER			810 WEST MAIN STREET ADAMS, MN 55909	

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

(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0176		_06/12/2013		ID Prefix	F0225		06/12/2013		ID Prefix	F0226		06/12/2013
	483.10(n)					483.13(c)(1)(ii)-(iii), (c)(2) -	(4)		•	483.13(c)		
LSC			•	<u> </u>	LSC				<u> </u>	LSC			_
			Correction					Correction					Correction
ID Prefix	F0329		Completed 06/12/2013		ID Prefix	F0428		Completed 06/12/2013		ID Prefix	F0441		Completed 06/12/2013
Rea #	483.25(I)		-		Rea #	483.60(c)				Rea #	483.65		
LSC			-		LSC								_
			•	1-					+-				
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			-		ID Prefix					ID Prefix			_
Reg. #			-		Reg. #					Reg. #			_
LSC			-		LSC				Щ.	LSC			
			0					0					O a man attaca
			Correction Completed					Correction Completed					Correction Completed
ID Prefix			•		ID Prefix					ID Prefix			
Reg. #					Reg. #								
LSC			-							LSC			_
			Correction					Correction					Correction
ID Deafin			Completed		ID Danfin			Completed		ID Deefin			Completed
			-										_
Reg. # LSC					Reg. # LSC					Reg. #			
			•	ļ	LSC				<u> </u>	LSC			
Reviewed By		Reviewed I	Ву	Da	te:	Signature of	Surve	yor:				Date:	
State Agency		MM/GPI	N	07	7/09/20			10160				07/	08/2013
Reviewed By	·	Reviewed I	Ву	Da	te:	Signature of	Surve	yor:				Date:	
CMS RO													
Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of					-						
	5/22/	/2013				Unco	rrecte	d Deficiencies	(CM	S-2567) Sent	to the Facility?	YES	NO

(L32)

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

					ND TRANSMITTAL E SURVEY AGENCY		D: 9KQN acility ID: 00754
MEDICARE/MEDICAID PROVIDER NO. (L1) 245509 2.STATE VENDOR OR MEDICAID NO. (L2) 015540300 5. EFFECTIVE DATE CHANGE OF OWN (L9)		3. NAME AND ADI (L3) ADAMS HEA (L4) 810 WEST M (L5) ADAMS, MN 7. PROVIDER/SUP	ALTH CARE CE	ENTER	(L6) 55909 02 (L7) 13 PTIP 22 CLIA	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation 7. On-Site Visit 8. Full Survey After Cor	2 (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other
6. DATE OF SURVEY 05/22/3 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF	FISCAL YEAR ENDING	DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	54 (L18) 54 (L17)	X B. Not in Comp	ce With quirements Based On: cceptable POC	1	And/Or Approved Waivers Of T 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNI 5. Life Safety Code * Code: B*	6. Scope of Servic 7. Medical Directo	or
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 54 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMARK At the time of the May 22, 2013 stand both health and life safety code along 17. SURVEYOR SIGNATURE Robin Lewis, HFE NE	ard survey the facili with the facility's pl	ity was not in substan an of correction. Pos Date:	itial compliance w			APPROVAL	Date: 07/18/2013
	PART II - TO I	BE COMPLETED	BY HCFA RI	` /	OFFICE OR SINGLE STA	TE AGENCY	(L20)
DETERMINATION OF ELIGIBILITY		20. COM	PLIANCE WITH C		21. 1. Statement of Finan	icial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA	-1513)
22. ORIGINAL DATE OF PARTICIPATION 01/01/1988 (L24) 25. LTC EXTENSION DATE:	23. LTC AGREEMI BEGINNING I (L41) 27. ALTERNATIVE	DATE	4. LTC AGREEMI ENDING DAT (L25)		01-Merger, Closure 02-Dissatisfaction W/ Reimbursem 03-Risk of Involuntary Termination	00 <u>INVOLUNT.</u> 05-Fail to Me nent 06-Fail to Me	ARY tet Health/Safety et Agreement
(L27)	A. Suspension of B. Rescind Susp		(L44) (L45)		04-Other Reason for Withdrawal	07-Provider S 00-Active	Status Change
28. TERMINATION DATE:	29.	INTERMEDIARY/C	ARRIER NO.		30. REMARKS		
	(L28)	03001		(L31)	Posted 7/25/2013 ML		
31. RO RECEIPT OF CMS-1539	32.	DETERMINATION O	OF APPROVAL DA	ATE			

(L33)

DETERMINATION APPROVAL



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 2548

June 5, 2013

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

RE: Project Number S5509022

Dear Ms. Hinkle:

On May 22, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

Adams Health Care Center June 5, 2013 Page 2

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904-5506

Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 22, 2013, 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 May 22, 2013 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

Adams Health Care Center June 5, 2013 Page 4

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 August 22, 2013 (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 November 22, 2013 (six months after the

Adams Health Care Center June 5, 2013 Page 5

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.

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

Sincerely,

Mark Meath

Mark Meath, Program Specialist

Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring

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

Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

5509s13.rtf

PRINTED: 06/04/2013 FORM APPROVED OMB NO. 0938-0391

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		245509	B. WING	JUN 1 4 2013	05/00/0040
es.	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		MN Dept of Health STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909	05/22/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO	BE COMPLETION
SS=E	The facility's plan of as your allegation of Department's accept bottom of the first passed as verification. Upon receipt of an arevisit of your facility validate that substar regulations has been your verification. 483.10(n) RESIDEN DRUGS IF DEEMED An individual residenthe interdisciplinary to §483.20(d)(2)(ii), has practice is safe. This REQUIREMENT by: Based on observation of the interdisciplinary to §483.20(d)(2)(ii), has practice is safe. This REQUIREMENT by: Based on observation of the interdisciplinary to §483.20(d)(2)(ii), has practice is safe.	f correction (POC) will serve f compliance upon the stance. Your signature at the age of the CMS-2567 form will on of compliance. Incceptable POC an on-site may be conducted to attained in accordance with the nattained in accordance with T SELF-ADMINISTER D SAFE It may self-administer drugs if eam, as defined by a determined that this It is not met as evidenced on, interview, and document led to ensure 4 of 4 residents 29) were assessed to safely eation through a nebulizer on 5/21/13, at 1:05 p.m. to 27 and R29 were observed bed with nebulizer solution icensed staff was observing f these four rooms or in the	F 176	Please note that our signature a response on the CMS-2567L do mean that we agree with either tagged deficiency or the evidence presented to support any determination of non-compliance respond and provide a written process to because the law requirements of the content of the	the ce ce. We lan of ires it. o le cent ms
	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNA	ATURE	ADMINISTRATOR	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safegyards 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.

LA

STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245509	B. WING	JUN 1 4 2013	0!	5/22/2013
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY! STATE HARRICODE 810 WEST MAIN STREET POSTER ADAMS, MN 55909		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	observation licensed came down the hally been filling portable filling room was local facility) while resider R3's diagnoses inclusions of beath of the pulmonal depression. R3's annual Minimum 2/24/13 indicated cogshortness of breath of lying flat and required all activities of daily library flat and required to the residence of the res	d practical nurse (LPN)-A way and said that she had oxygen tanks (the oxygen ated on another area of the ats were lying down. Ided but not limited to chronic ry disease, hemiplegia and an Data Set (MDS) dated gnitive impairment, had or trouble breathing when dextensive to total assist for ving (ADL's.) R3's medical record they ysician order dated 1/27/12, used to clear the bronchi) 0.5 mg in 3 milliliter (ml) day (QID) which was ent through the use of a atment. Further review of vealed ASSESSMENT NT TON OF MEDICATIONS and the resident had been hable to safely ations which also included added but not limited to	F 17	The Director of Nursing, the Staff Development and/or their designee are responsibl to monitor for compliance. Results will be reported monthly to the Quality Improvement Committee for review and/or further recommendations.		6/12/13

그리는 사람들이 사람들이 사용하다 하는 것이다.	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			JUN 14 2013		re survey Mpleted
		245509	B. WING	_	MN Dept of Health	05/	/22/2013
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		8	REET ADDRESS, CITY, STATE, ZIP CODE 310 WEST MAIN STREET ADAMS, MN 55909		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 176	included current phy DuoNeb 2.5 mg - 0. Further review of th ASSESSMENT TOO SELF-ADMINISTRA dated 7/19/11, indic assessed and was self-administer medidentified due to cogrealistic for her to dimedication. R27's diagnoses incanxiety, depression, coughing. R27's annual MDS cognitive impairment total assist for all ADDuring review of the included current phy DuoNeb 2.5 mg - 0. four hours while wall medical record reve ASSESSMENT TOO	e R17's medical record they ysician order dated 10/7/11, 5 mg in 3 ml solution QID. e medical record revealed OL FOR RESIDENT ATION OF MEDICATIONS ated the resident had been unable to safely ications. The assessment unable to safely ications. The assessment unable to safely ications are discountied in the spense own respiratory. Cluded but not limited to and labored respiration and dated 2/12/13 indicated it, and required extensive to DL's. R27's medical record they visician order dated 4/8/13, 5 mg in 3 ml solution every ke. Further review of the aled no current	F	1176			
	respiratory failure. R29's quarterly MDS moderate cognitive i	luded but not limited to dated 2/7/13 indicated mpairment, and required					
	extensive to total as During review of the	sist for all ADL's. R29's medical record they					

	OF CORRECTION	IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY MPLETED
		245509	B. WING	ı <u>. </u>	JUN 1 4 2013	05/	/22/2013
	PROVIDER OR SUPPLIER HEALTH CARE CENT	TER		81	MN Dopt of Health REET ADDRESS, CITY, STATE CAUSING ODE 10 WEST MAIN STREET DAMS, MN 55909		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	N 155 S. C.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 176	DuoNeb 2.5 mg - 0 Further review of the R29 chose to have administering all moderated by the R29 chose to have administering all moderated R3, R17, Redication treatme four residents and the left alone while the running. LPN-A state up and go back in the LPN-A further verification were unable to self-was unaware if self assessments had be R27 and R29. During interview on director of nursing (require self-administ to be completed be nebulizer medication assessments and control of the resident record. DO R27 and R29 were medication which all Review of SELF-ADMEDICATION police each resident had the determined that the	ysician order dated 4/29/13, .5 mg in 3 ml solution QID. he medical record revealed facility responsible for edication. 5/21/13, at 1:07 p.m. LPN-A 27 and R29's nebulizer nt had been set-up for these then each residents had been medication treatment was ated, "We hook them [resident] o monitor while they're on it." ed R3, R17, R27 and R29 administer medication and administration of medication teen completed for R3, R17, .5/21/13, at 1:15 p.m. the DON) reported all residents ater of medication assessment fore they can be left alone with	F	1176			

AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		0.0000		JUN 1 4 2013	
		245509	B. WING _	Mily Dont of Houlin	05/22/2013
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		BTREET ADDRESS, CITY, STATE 地户 CODE 810 WEST MAIN STREET ADAMS, MN 55909	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
	responsibility to the 483.13(c)(1)(ii)-(iii), INVESTIGATE/REP ALLEGATIONS/IND The facility must not been found guilty of mistreating residents had a finding entered of residents or misar and report any know court of law against a indicate unfitness for other facility staff to to relicensing authorities. The facility must ensinvolving mistreatmen including injuries of unisappropriation of misappropriation of misappropriatio	facility. (c)(2) - (4) ORT IVIDUALS employ individuals who have abusing, neglecting, or so by a court of law; or have dinto the State nurse aide abuse, neglect, mistreatment oppropriation of their property; ledge it has of actions by a can employee, which would service as a nurse aide or he State nurse aide registry es. ure that all alleged violations and, neglect, or abuse, nknown source and esident property are reported liministrator of the facility and cordance with State law procedures (including to the iffication agency). e evidence that all alleged has a must ital abuse while the gress. estigations must be reported	F 17		to als ace

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION IGJUN-1 4 2013	2013 (X3) DATE SURVEY COMPLETED	
		245509	B. WING	<u>; </u>	MN Dept of Health	0,	5/22/2013
	PROVIDER OR SUPPLIER HEALTH CARE CENT			1	TREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909	1 00	JIZZ ZU13
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 225	Continued From page	ge 5	F2	225	5		
	by: Based on interview facility failed to reponeglect and mistreat designated state agree Facility Complaints [Department of Healt (R20, R6, R43) reviews Findings include: R20 had an allegation 12/20/12 however; Cuntil the next day on R6 had an allegation however; OHFC had which was two days R43 had an allegation however; OHFC had next day which was two days When interviewed at licensed social worked discovery of a concertaff are to ensure the needs were met prior next step was for staff wing nurse if staff couring their wing nurse to be immediately info-SW gathered all info	of neglect on 4/2/13 not been notified until 4/4/13 after incident was found. n of mistreatment on 3/18/13 not been notified until the on 3/19/13. 8:46 a.m. on 5/21/13, the					

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

AND PLA	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	DING JUN 1 4 2	013 (X3) C	(X3) DATE SURVEY COMPLETED	
		245509	B. WING	MN Dent of Ho-	elth	05/22/2013	
ļ	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 810 WEST MAIN STREET ADAMS, MN 55909		7072272010	
(X4) II PREFI TAG	X (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	IX (EACH CORRECTIVE ACTIO	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 226 SS=D	all the information in immediately. The Li more than ten to fift been made aware of before the initial repromputer. On reviet R6 and R43 with the facility staff had failed suspected abuse or administrator, DON immediately and the adult reports comple were not made to the During an interview director of nursing (I was all incidents of smistreatment must be administrator, DON, immediately and a reimmediately to OHFC facility staff failed to abuse or mistreatme and social services in R43 and verified that completed for R20, F to the OHFC immediately Review of the Report Incident an undated printial report must be facility administrator, social worker and MD	needed, she made the report SW stated it had never been een minutes after LSW had of a vulnerable adult concern fort was made to OHFC on the wing the allegations for R20, a LSW the LSW verified the ed to report incidents of mistreatment to the and social services a LSW verified the vulnerable eted for R20, R6, and R43 are OHFC immediately. at 11:32 a.m. on 5/22/13 the DON) stated her expectation suspected abuse or the report incidents of suspected abuse or the report was to be completed C. The DON verified the report incidents of suspected and to the administrator, DON mediately for R20, R6 and the vulnerable adult reports R6, and R43 were not made ately. Sing a Vulnerable Adult coolicy, instructed staff to: reported immediately to the the director of nursing, the DH. "Immediately means but ought not to exceed 24 of the incident."	F 226	225			

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	riple construction NGJUN 1 4 2013		E SURVEY IPLETED
		245509	B. WING	MN Dept of Health Rochester	05/:	22/2013
ADAMS	PROVIDER OR SUPPLIER HEALTH CARE CENT			STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTROL INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
Find a second se	policies and procedumistreatment, negler and misappropriation. This REQUIREMENT by: Based on interview a facility failed to follow allegations of verbal mistreatment of resid director of nursing an and the facility failed designated state age Facility Complaints [OMinnesota Departme 5 residents (R20, R6, prohibition. Findings in R20 had an allegation 12/20/12 however; Oluntil 12/21/12. R6 had an allegation nowever; OHFC had in 14/4/13. R43 had an allegation nowever; OHFC had in 14/4/13. Review of the Reporting port must be reported dministrator, the directions and the direction in the direc	relop and implement written ares that prohibit ct, and abuse of residents of residents of resident property. T is not met as evidenced and document review, the reliance to the administrator, ad social worker immediately to report immediately to report immediately to ncies (Office of Health DHFC] a division of nt of Health [MDH]) for 3 of R43) reviewed for abuse include: In of verbal abuse on HFC had not been notified until	F 22	• Adams Health Care Center staff will report allegations verbal abuse, neglect and mistreatment immediately the administrator of the facility and to other official (OHFC, CEP) in accordance with State Law through established procedures. • Training provided on June 2013 for all staff regarding reporting responsibilities an following the procedures of the Abuse Prevention and Vulnerable policies. • The Administrator, Social Services and/or their design will monitor to assure all reports of abuse are being reported and investigated timely.	to ls see	6/12/13

AND PLA	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION 1 4 2013	(X3) DATE SURVEY COMPLETED
		245509	B. WNG	MN Dopt of Hosen	05/00/0040
	F PROVIDER OR SUPPLIER S HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909	05/22/2013
(X4) IE PREFI TAG	X EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 329 SS=E	as possible, but oug after discovery of the When interviewed a licensed social work staff failed to follow of suspected abuse administrator, DON immediately for R20 vulnerable adult report and R43 were not mainterviewed at director of nursing (EVulnerable Adult Incident of nursing, the "Immediately to the fadirector of nursing, the "Immediately means ought not to exceed a the incident." The Dot failed to report incide mistreatment to the associal services immediately for R20, R to the OHFC immediately mediated for R20, R to the OHFC immediated	the not to exceed 24 hours e incident." It 8:46 a.m. on 5/21/13, the er (LSW) verified the facility the policy to report incidents or mistreatment to the and social worker, R6 and R43 and verified the orts completed for R20, R6, ade to the OHFC 11:32 a.m. on 5/22/13 the OON) verified the Reporting a dent undated policy, itial report must be reported cility administrator, the ne social worker and MDH. as soon as possible, but 24 hours after discovery of ON verified the facility staff ints of suspected abuse or indinistrator, DON and diately for R20, R6 and R43 erable adult reports 16, and R43 were not made ately. SIMEN IS FREE FROM UGS regimen must be free from An unnecessary drug is any cessive dose (including for excessive duration; or nitoring; or without adequate	F 22	26	ng

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		DING	(X3) DATE SURVEY COMPLETED	
		245509	B. WING		05/22/2042	
10 9740 SUSTA 0	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		MN Dept of Health STREET ADDRESS, CITYRSTATE; ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909	05/22/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE COMPLÉTION	
F 329	combinations of the Based on a comprei resident, the facility who have not used a given these drugs un therapy is necessary as diagnosed and do record; and resident drugs receive gradus behavioral interventi	reasons above. nensive assessment of a must ensure that residents antipsychotic drugs are not nless antipsychotic drug v to treat a specific condition ocumented in the clinical s who use antipsychotic al dose reductions, and	F3	 In-service training provide on June 12, 2013 to licens nursing staff who adminis medications to monitor for irregularities, effectivenes gradual dose reduction or tapering of medications. The Director of Nursing, S Development and/or their designee are responsible to monitor for compliance. 	ted ter r s,	
	by: During document refailed to identify the inneeded (PRN) Tramagiving the medication the pain medication of 10 resident (Frationale (justification antianxiety medication failed to ensure a companyonotic medication frailed to notify physici of 10 resident (R7) whe medication to control clinical justification for antidepressant for moralized to motification for antidepressant for moralized to motify physicity for the control clinical justification for antidepressant for moralized to motify the control clinical justification for antidepressant for motification f	or 1 of 10 residents (R8); an of an elevated pulse for 1 no received cardiac heart rate; failed to provide				

AND	D PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		NG		ATE SURVEY IMPLETED
			245509	B. WING		0.6	5/22/2013
		PROVIDER OR SUPPLIER HEALTH CARE CENTI	FR		STREET ADDRESS, CATYNSTATE, ZIP CODE 810 WEST MAIN STREET	1 00	012212013
					ADAMS, MN 55909		
Р	X4) ID REFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTROL OF THE STATE O	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BF	(X5) COMPLETION DATE
ſ	F 329	Continued From pag findings were found medications review.	ge 10 during the unnecessary	F 32	29		
		Findings include:					
		reason/pain intensity and use of other non interventions used. A medication was some symptoms without a R9 indicated, during at 2:47 p.m., they had	ng identification of the confidence of the confi				
		3/31/2013 noted cogr	num Data Set (MDS) dated nitive status as moderate e recall issues and had			14-9	
	1	The resident was pre	ed 5/14/2013 were reviewed. scribed Tramadol HCL 4 hours as needed for pain.				
		Medication sheets an 4/13, and 5/13 were r noted for the as need medication use:	d progress notes for 3/13, eviewed. The following was ed Tramadol pain				
	1	nothing was documen was given or the pain	on 5/13, 5/16, 5/19 however; ted regarding the reason it intensity, if effective, or ogical interventions had				
	(Framadol was given o causing anxiety; 4/20 d down " ; 4/22 however	n 4/19 related to nose clots requested a pill to " calm , no indication for use				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ILTIPLE CONSTRUCTION		(X3) DA	TE SURVEY MPLETED
		245509	B. WING	·	MN Dept of Health Rochester	0.5	/22/2013
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CI 810 WEST MAIN S ADAMS, MN 559	TY, STATE, ZIP CODE TREET	1	12212010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX EACH CO	DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD ERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
	given; 4/25 " too ne Tramadol was given 3/11, 3/15, 3/16, 3/2 lacked indication the was there any inforreffective for pain reliinterventions had be the pain medication. complained of " ner something to aid sle Monthly pharmacy rethrough 5/15/2013 will did not identify any is Tramadol being used symptoms. Even tho the Tramadol for pain Physician notes review comments that R9 's controlled on current On 5/22/2013 at 12:3 (RN)-D was interview Tramadol prn pain mathe effectiveness of the documented after receives the Tramadol April and May 2013 not Tramadol was given incidents of no documuse and if the medica 5/22/2013 at 12:55 p. family (F)-A will not less the tramadol was given family (F)-A will not less the tramadol was given the family (F)-A will not less the tramadol was given the family (F)-A will not less the tramadol was given the family (F)-A will not less the tramadol was given the family (F)-A will not less the tramadol was given the family (F)-A will not less the tramadol was given the family (F)-A will not less the tramadol was given the family (F)-A will not less the family (F)-A will not	and on 3/2013: 3/2, 3/4, 3/10, 10, 3/22, 3/25, all these dates of medication was given nor mation as to pain intensity, if iter or if non- pharmacological ten used prior to the use of Tramadol given on 3/28 for vousness " requesting ep. Eviews dated 9/14/2012 rere reviewed. The reviews saues with the use of the prn of for none pain related ugh the physician ordered in control only. Ewed: 5/15/2013 and a pain is adequately regime. By p.m., a registered nurse redered nurse regime. By p.m., a registered nurse redered nurse regime. By p.m., a registered nurse redered nurse regime. By p.m., a registered nurse regime.	F3	329			

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	LTIPLE CONSTRUCTION DING			TE SURVEY MPLETED
		245509	B. WING	JUN_1	4 2012	05	5/22/2013
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROP	DBF	(X5) COMPLETION DATE
	Tramadol to be use On 5/22/2013 at 1:4 (DON) was question Tramadol for R9 and pain, as well as other resident was on for lack of consistent do use and if the medic control the DON said documenting in nurse pain medications are the Tramadol was gived for anxiety symmot given orders to use and if the medication without control the DON said documenting in nurse pain medications are the Tramadol was gived for anxiety symmot given orders to use R23 was on Clonaze medication without control the DON said was discovered to the continuer of the Clonaze to the commendation on the commendation of the Clonaze the commended at this commended at this commended at this control of the clonaze the commended at this commended at this control of the clonaze the the clo	d for anxiety. 5 p.m., the director of nursing ned about the use of d she said it was used for er pain medications the pain control. As far as the ocumentation for indication of ration was effective for pain d the staff should be sing notes when as needed egiven. The DON indicated wen for pain and not to be aptoms as the physician had use the Tramadol for anxiety. The pain an antianxiety linical justification and ed use. The pain and not to be aptoms as the physician had use the Tramadol for anxiety. The pain an antianxiety linical justification and ed use. The pain and not to be aptoms as the physician and ed use. The pain and not to be aptoms as the physician and eduse. The pain and not to be aptoms as twice a day. The pain and not to be aptoms and the pain and the pain and the physician and the pain an	F 3	329			

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I			245509	B. WING		MN Dept of Health	0!	5/22/2013
		PROVIDER OR SUPPLIER HEALTH CARE CENT			81	EET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET DAMS, MN 55909		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
		was not tapered at the Clonazepam effective requested from 2/20 However, no monitor February to May 201 Medical doctors prog 3/20/2013, 2/20/2013 the notes addressed of the Clonazepam in On 5/21/2013 at 1:05 clinical care coordinated was interviewed. She anxiety disorder. RN came to the facility for anxious about returning RN-A verified R9 has symptoms/behaviors four months. RN-A all the PA had not docur why a tapering of the contraindicated at this R8 was not comprehe contraindicated at this R8 was not comprehe contraindicated at this R8 was admitted to the diagnoses including: whistory of psychosis. Current physician order for tablet by mouth every date of 10/7/11.	reness monitoring was 13 through 5/21/2013. ring was completed from 3. gress notes dated 4/17/2013, 3, were reviewed. None of the use and/or effectiveness nedication for anxiety. 5 p.m. and 1:30 p.m., a etor -registered nurse (RN)-A e identified R23 as having an -A said that R9 originally or short term stay and was ing back to assisted living. In 't had any anxiety documented for the past so verified the physician and mented a justification as to Clonazepam was setime. Pensively assessed for of the hypnotic (Trazodone) sleep. The facility in 3/3/04 with vascular dementia with Trazodone 50 mg take one night at bedtime with a start medical record, revealed d with no evidence of a dentify actual or potential	F3	29			
			The state of the s					

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245509	B. WING	JUN 1 4 2013	0!	5/22/2013	
i	F PROVIDER OR SUPPLIER S HEALTH CARE CENT			STREET ADDRESS, CITY, STATE ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(X4) II PREFI TAG	X (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE	(X5) COMPLETION DATE	
F 32	non-pharmacologic sleep. Also there we monitoring of sleep determine if the me The facilities SLEEP policy dated 5/12/11 the purpose was to for a base line of all but had not address assessment should who has a dx of sleep medication to enhar On 5/21/13, at 10:54 (RN)-B was intervien to sleep assessment a.m., RN-B identified had been completed comprehensive sleep completed for R8. During interview on director of nursing (Director of nursing (Dire	al intervention to promote as no evidence of ongoing quality or hours of sleep to dication was effective. PATTERNS FLOW SHEET I was reviewed. It identified gather data on all admission residents receiving hypnotics sed the need for a sleep be completed on any resident ep disturbance, uses not esleep. If a.m., a registered nurse ewed and verified there was not completed for R8. At 11:35 of a sleep pattern flow sheet on 1/21/11 but verified a presessment had been seed for sleep but for N indicated the sleep pattern refacility but no sleep nupleted. DON verified the sed R8 had a sleep wake the Trazodone to aid in than 110 and staff had not not at included hypertension and ad physician order for old is a beta-adrenergic used for treating high blood abnormal rhythms of the	F 3:	29			

1	AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING		ATE SURVEY OMPLETED
L			245509	B. WING	111111111111111111111111111111111111111	0!	5/22/2013
		PROVIDER OR SUPPLIER HEALTH CARE CENTI	ER		STREET ADDRESS, CITY, STATE, ZIP CO 810 WEST MAIN STREET PROTECTION ROOTSTAND ADAMS, MN 55909	DE	JILLILO TO
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE	(X5) COMPLETION DATE
		extended release tall daily-call if pulse if or During review of pulse pulse greater than 11 physician had not be order. On 1/21/13 pulse 113. During review of the Condition or Status pulse directed the charge resident's physician of there had been instructed the charge in the resident's physician of changes in the resident's physician had elevated pulse on each order was to update to During interview on 5 licensed practical nurverified physician had elevated pulse on each order was to update to During interview on 5 was not sure how the physician order to be The DON would have follow the physician order than 110 R28 lacked a clinical ref an antidepressant had allowed the physician order for Ception or the Ception of the physician order for Ception or the physician order for Ception order for Ception order for Ception or the physician order for Ception order for Cep	ke one tablet by mouth ver 110. se documentation R7 had a 10 four times and the een notified per the physician alse was 129 and 115, on 3, 2/22/13 126 and 4/9/13 Change in a Resident's policy dated 8/9/11, the policy purse would notify the pron-call physician when actions to notify the physician ident's condition. /22/13 at 12:04 p.m. se admission coordinator of not been notified of the physician. /22/13 at 1:18 p.m. DON staff had missed the updated if pulse above 110. expected licensed staff to rader as written and update to beats per minute. rationale as to why a taper had not been completed. actility on 5/20/11 with and depression. R28 had lexa (antidepressant) 10 mouth daily. Last change	F 3			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER (SURPLIFIED)

AND PLAN OF CORRECTION	S 110 (170)	VSUPPLIER/CLIA ATION NUMBER:	26 320	TIPLE CONSTRUCTIONS	JUN 1 4 2013	COL	TE SURVEY MPLETED	
	2	45509	B. WING_		MN Dept of Health		/22/2013	
NAME OF PROVIDER OR S			\$	STREET ADDRESS, C 810 WEST MAIN : ADAMS, MN 55	CITY, STATE, ZIP CODE STREET			
PREFIX (EACH DE	MARY STATEMENT OF DEF EFICIENCY MUST BE PREC ORY OR LSC IDENTIFYING	EDED BY FULL	ID PREFIX TAG	(EACH CO	IDER'S PLAN OF CORRECTIO ORRECTIVE ACTION SHOULD FERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
During inter indicated a regarding noverified ther done since indicated. During inter registered in that there we medications 483.60(c) Dial IRREGULATE The drug regreviewed at pharmacist. The pharma the attending nursing, and This REQUIF by: During docute failed to act of for drug irregito identify ar physician and Indication for pain medication.	RUG REGIMEN REV	on 4/23/12 (a dosage and ocumentation ald not be 23 p.m. If this surveyor rapering IEW, REPORT Int must be y a licensed Tregularities to irector of eacted upon. The as evidenced Triew the facility ommendations parmacist failed larities to the or the following: PRN) Tramadol emedication	F 42	8 • All lack effe redu mon phys nurs on Junes mediand pmediand pme	medications irregular of indication, ectiveness, and gradua action or tapering are nitored by the pharma sician and director of sing. ervice training provid une 12, 2013 to licen- ting staff who admini- ications to review po- procedure for proper ication usage. Director of Nursing, elopment and/or their gnee are responsible to itor for compliance or lar basis.	being acist, led sed ster licy Staff	6/12/13	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (VX) PROVIDED CHARGE (CHARGE)

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPI	LE CONSTRUCTION 1 4 2013		TE SURVEY MPLETED
		245509	B. WING	_	MN Dept of Health Rochester	05	5/22/2013
ĺ	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		8	REET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET ADAMS, MN 55909	1 00	72212010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	failed to provide clin the continued use of 1 of 10 residents (R comprehensive sleet prior to the use of a 10 residents (R8); farelevated pulse for 1 received cardiac metailed to provide clin use an antidepressant of 10 residents (R2) these findings were medications review. Findings include: R9 lacked document management including reason/pain intensity and use of other non interventions used. In medication was som symptoms without a R9 indicated, during at 2:47 p.m., they ha R9 's Quarterly Minimal 3/31/2013 noted cogimpairment with som occasional mild pain. Physician orders date The resident was pre (Ultram) 50 mg every Medication sheets and the resident sheets and the continued of the resident sheets and the continued of the resident was pre (Ultram) 50 mg every Medication sheets and the resident sheets and the continued of the continued o	ical rationale (justification) for f an antianxiety medication for 23); failed to ensure a p assessment was completed hypnotic medication for 1 of ailed to notify physician of an of 10 resident (R7) who dication to control heart rate; ical justification for continued ant for more than one year for 28) who received Celexa. All found during the unnecessary found during the unnecessary attion related to pain effectiveness of medication, pharmacological Also, the as needed pain etimes used for anxiety physician order. Initial interview on 5/19/2013 d pain in the shoulder area, mum Data Set (MDS) dated in itive status as moderate e recall issues and had and 5/14/2013 were reviewed. Scribed Tramadol HCL 4 hours as needed for pain. In progress notes for 3/13, eviewed. The following was	F	128			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	MN Dopt of Hants		TE SURVEY MPLETED
		245509	B. WING	Lucate de	05	/22/2013
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909		12212013
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	, , , , , , , , , , , , , , , , , , , ,	BE	(X5) COMPLETION DATE
	nothing was documed was given or the paid what non-pharmacon been used. Tramadol was given causing anxiety; 4/20 down"; 4/22 however 4/25 "too nervous to the too nervous to the term of the pain medication the was there any inform effective for pain religinterventions had been the pain medication. complained of "nervisomething to aid sleet through 5/15/2013 will did not identify any is through 5/15/2013 at 12:3 (RN)-D was interview. On 5/22/2013 at 12:3 (RN)-D was interview.	on 5/13, 5/16, 5/19 however; ented regarding the reason it in intensity, if effective, or plogical interventions had on 4/19 related to nose clots or requested a pill to "calmer, no indication for use given; o sleep." on 3/2013: 3/2, 3/4, 3/10, 0, 3/22, 3/25, all these dates medication was given nor nation as to pain intensity, if effor if non-pharmacological en used prior to the use of Tramadol given on 3/28 for ousness" requesting ep. eviews dated 9/14/2012 ere reviewed. The reviews issues with the use of the profit for none pain related ugh the physician ordered in control only.	F 4:	128		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- NO		E CONSTRUCTION JUN 1 4 2013	(X3) DAT	TE SURVEY MPLETED
		245509	B. WING		MN Dept of Heath	05	/22/2013
ADAMS	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		81	EET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET DAMS, MN 55909		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
	be documented after receives the Tramaco April and May 2013 Tramadol was given incidents of no documented after the medication but F-A will not let the medication was question. Tramadol to be used On 5/22/2013 at 1:48 (DON) was question. Tramadol for R9 and pain, as well as other resident was on for plack of consistent do use and if the medication with DON said documenting in nursipain medications are the Tramadol was given orders to us R23 was on Clonaze medication without clarationale for continue. Physician orders date R23 currently was pre(antianxiety) medication.	r each time the resident dol. After reviewing March, medication record for when to R9 there were several mentation for indication for ation was effective or not. On o.m., RN-D stated R9's family staff use an antianxiety was okay with the tramadol tianxiety medication. In physician order for a for anxiety. 5 p.m., the director of nursing ed about the use of about the use of a she said it was used for repain medications the pain control. As far as the cumentation for indication of ation was effective for pain at the staff should be notes when as needed given. The DON indicated wen for pain and not to be ptoms as the physician had see the Tramadol for anxiety. pam an antianxiety inical justification and duse. and 4/17/2013 were reviewed. escribed Clonazepam on 0.5 mg twice a day.	F	128			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTIONUN 1 4 2013				(X3) DATE SURVEY COMPLETED		
		245509	B. WING		MN Dopt of Health Rochest	0.5	:10010040		
NAME OF PROVIDER OR SUPPLIER ADAMS HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909					
PF	REFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F	day to twice a day 0.25 mg at either If a reduction is no clinical rationale. documented "no con 3/21/2013. However, no mon the justification as Clonazepam was nor was there any the Clonazepam effect requested from 2/However, no mon February to May 2 Medical doctors proceed and the Clonazepam of the Clonazepam On 5/21/2013 at 1 clinical care coord was interviewed. So anxiety disorder. If came to the facility anxious about return RN-A verified R9 however and the PA had not document of the PA had not doc	ecreased from three times a property and pro	F	128					

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILD	JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245509	B. WING	JUN 1 4 2013	0.5	5/22/2013	
NAME	OF PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	/ LIZO TO	
ADA	MS HEALTH CARE CE			810 WEST MAIN STREET ADAMS, MN 55909			
(X4) PRE TA	FIX (EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE	
F	history of psychologurent physician a physician order tablet by mouth edate of 10/7/11. Further review of Trazodone was sleep assessment causes of a sleep non-pharmacolog sleep. Also there monitoring of sleep determine if the mathematic that the purpose was for a base line of but had not addressessment show who has a dx of smedication to enh On 5/21/13, at 100 (RN)-B was interno sleep assessment had been completed for R8. During interview of director of nursing Trazodone was not depression. The Datool was utilized in assessment was on physician had identified the cycle and reference.	ing: vascular dementia with sis. In orders were reviewed. It noted for Trazodone 50 mg take one very night at bedtime with a start the medical record, revealed tarted with no evidence of a to identify actual or potential problem, or evaluate ical intervention to promote was no evidence of ongoing up quality or hours of sleep to nedication was effective. EP PATTERNS FLOW SHEET 11 was reviewed. It identified to gather data on all admission all residents receiving hypnotics assed the need for a sleep lid be completed on any resident reep disturbance, uses		428			
	better sleep.	ed the Trazodone to aid in					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			3) DATE SURVEY COMPLETED	
		245509	B. WING		JUN 1 4 2013	05	/22/2013
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F 428	,	ge 22 er than 110 and staff had not	F4	28			
	updated the physicia R7 had diagnoses the						
	Metoprolol (Metopro blocking agent that is pressure, heart pain and some neurologic	lol is a beta-adrenergic s used for treating high blood , abnormal rhythms of the c conditions.) 100 mg se one tablet by mouth				9000	
	pulse greater than 1 physician had not be order. On 1/21/13 pu	se documentation R7 had a 10 four times and the en notified per the physician alse was 129 and 115, on 3, 2/22/13 126 and 4/9/13					
	Condition or Status p directed the charge n resident's physician o	or on-call physician when actions to notify the physician					
,	verified physician had	se admission coordinator I not been notified of the episode and the current					
<u> </u>	vas not sure how the physician order to be Γhe DON would have	/22/13 at 1:18 p.m. DON staff had missed the updated if pulse above 110. expected licensed staff to rder as written and update					

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		245509	B. WING		05/22/2013	
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREE Rochesta ADAMS, MN 55909	- VOILLIEUTO	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION	
SS=F	when greater than R28 lacked a clinical of an antidepressar R28 was admitted to diagnoses of demer physician order for mg take one tablet with the Celexa was During interview on indicated a note had regarding not chang verified there had not done since as to whindicated. During interview on registered nurse (RI that there was no farmedications. 483.65 INFECTION SPREAD, LINENS The facility must estanfection Control Prosafe, sanitary and cot help prevent the dof disease and infection Control The facility must esta Program under which (1) Investigates, continute facility; (2) Decides what prosage and infection control to the facility; (2) Decides what prosage and infection control to the facility; (2) Decides what prosage and infection control to the facility; (2) Decides what prosage and infection control to the facility; (2) Decides what prosage and infection control to the facility; (2) Decides what prosage and infection control to the facility; (2) Decides what prosage are the facility; (2) Decides what prosage and infection control to the facility; (2) Decides what prosage are the facility; (2) Decides what prosage are the facility and the facility; (2) Decides what prosage are the facility and the facility are the facility; (2) Decides what prosage are the facility and the facility are the facility are the facility and the facility are th	al rationale as to why a taper at had not been completed. To facility on 5/20/11 with and and depression. R28 had Celexa (antidepressant) 10 by mouth daily. Last change a 10/7/11. To facility on 5/20/11 with and celexa (antidepressant) 10 by mouth daily. Last change a 10/7/11. To facility on 5/20/11 with and the celexa depression and the celexa (antidepressant) 10 by mouth daily. Last change a 10/7/11. To facility at 1:15 p.m. DON and the celexa dosage and been any documentation and the celexa dosage and been any docu	F 44	An infection control surveillance analysis and trending will be complete	vill to und tin e. ud/or ible tily ut	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/04/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED 245509 8. WING 05/22/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE 810 WEST MAIN'S PREETHealth ADAMS HEALTH CARE CENTER ADAMS, MN 55909 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 441 Continued From page 24 F 441 (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. This REQUIREMENT is not met as evidenced Based on interview, and document review, the facility failed to develop and maintain a comprehensive infection control surveillance program for residents that included analysis of infections to assist in preventing the development and transmission of infections. In addition, the facility failed to ensure an employee health surveillance program to analyze trends and patterns as included in the overall infection

program. That deficient practice had the potential

to affect all 39 residents in the facility.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/04/2013 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION 1 4 2013 OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED MN Dept of Health 245509 B. WING 05/22/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS HEALTH CARE CENTER ADAMS, MN 55909 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 441 Continued From page 25 F 441 Findings include: A review of the facilities Infection Control surveillance Log(s) from January 1, 2013, through April 30, 2013, the following had not been included on the Infection Control Surveillance Log (s): Location of resident in facility for all months reviewed; Organism of infection or x-ray results for residents who had a culture taken or x-ray; Signs and symptoms of infection for all residents. The log(s) also lacked indication of the effectiveness of the treatment which includes antibiotics for any of the resident infections. During interview on 5/22/13, at 11:18 a.m. the infection control nurse/admission coordinator indicated the infection control reports were filled out by the nurses once a fax comes back or if identified on rounds a form is completed and at the end of the month she goes through the resident 's chart to make sure they had not missed any infections. The infection control nurse indicted they looked at the infection report sheets every day and then would take them and fill in the missing information on the monthly infection report. On reviewing the infection logs given to the surveyor the infection control nurse verified the reports had not identified culture results and had not identified room number, some had date or left blank.

During interview on 5/22/13, at 12:12 p.m. the infection control nurse indicated employees each had an individual attendance record but verified there had been no tracking and trending of employee infections and how this may affect the residents acquiring infections or how the facility could educate staff to prevent the spread of

		AND HUMAN SERVICES				D: 06/04/2013 M APPROVED
		& MEDICAID SERVICES				O. 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILL	JLTIPLE CONSTRUCTION DING		ATE SURVEY OMPLETED
		245509	B. WING	3HN 1 to 2010	0.	5/22/2013
NAME OF	PROVIDER OR SUPPLIER	2		STREET ADDRESS, CITY, STATE, ZIP CODE		
ADAMS	HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET of Health ADAMS, MN 55909		
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F 441	infections through e	ducation.	F 4	441		
	director of nursing (I tracking forms were trend. The DON indi why they call in so n	5/22/13, at 1:01 p.m. the DON) verified infection not completed to track and cated staff does not tell us ot able to track and trend. If someone comes in sick m home.				
	review dated 2008, it federal regulation lar control program and separate record of in resident with an infection, causative a infection and describ measures were taken	n to prevent the spread if the tin the facility. There was no				

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMI			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00754		B. WING		05/22/2013
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
ADAMS H	EALTH CARE CENTER		810 WEST ADAMS, M	MAIN STREET N 55909	Г	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
2 000	00 Initial Comments			2 000		
	****ATTENTION*****					
	NH LICENSING CORRECTION ORDER					
	144A.10, this correction pursuant to a survey. found that the deficier herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart. Determination of where corrected requires corrected requires correquirements of the runumber and MN Rule. When a rule contains comply with any of the	ther a violation has been mpliance with all ule provided at the tag number indicated belo several items, failure to be items will be consider	ed it is d ation ce of en w. o			
	re-inspection with any result in the assessme	ack of compliance upo ritem of multi-part rule ent of a fine even if the ng the initial inspection	will item			
	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: On May 19, 20, 21, 22, 2013, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and				Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softw. Tag numbers have been assigned to Minnesota state statutes/rules for Nur Homes.	

Minnesota Department of Health

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

STATE FORM 9KQN11 If continuation sheet 1 of 31

TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUMBER 1			` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00754		B. WING		05/22/2013		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	FADDRESS, CITY, STATE, ZIP CODE				
ADAMS H	EALTH CARE CENTER		1	ST MAIN STREET , MN 55909				
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2 000	Continued From page 1			2 000				
	Certification Program; 18 Wood Lake Drive SE, Rochester, MN 55904.				The assigned tag number appears in far left column entitled "ID Prefix Tag The state statute/rule out of complian listed in the "Summary Statement of Deficiencies" column and replaces th Comply" portion of the correction ord. This column also includes the finding which are in violation of the state stat after the statement, "This Rule is not as evidence by." Following the survey findings are the Suggested Method o Correction and Time period for Corre PLEASE DISREGARD THE HEADIN THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THE WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTA STATETUTES/RULES.	g." ice is e "To er. s cute met yors f ction. IG OF		
21375	MN Rule 4658.0800 S Program	Subp. 1 Infection Contr	ol;	21375				
	home must establish	control program. A nu and maintain an infecti gned to provide a safe a	on					
	by: Based on interview, a facility failed to develo comprehensive infect	t is not met as evidend and document review, the op and maintain a ion control surveillance that included analysis	he e					

Minnesota Department of Health

STATE FORM 9KQN11 If continuation sheet 2 of 31

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUM			` '	CONSTRUCTION	(X3) DATE S			
				A. BUILDING: _				
		00754		B. WING		05/2	22/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE			
ADAMS H	EALTH CARE CENTER			ST MAIN STREET 6, MN 55909				
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21375	Continued From page 2			21375				
21373	infections to assist in and transmission of ir facility failed to ensure surveillance program patterns as included i program. That deficie to affect all 39 resider Findings include: A review of the facilitis surveillance Log(s) from April 30, 2013, the folincluded on the Infect (s): Location of resider reviewed; Organism of for residents who had Signs and symptoms. The log(s) also lacked effectiveness of the transibiotics for any of the transibiotics for any of the During interview on 5 infection control nurse indicated the infection out by the nurses oncidentified on rounds at the end of the month resident's chart to maissed any infections indicted they looked a every day and then with missing information or report. On reviewing the surveyor the infect the reports had not id	preventing the development of the an employee health to analyze trends and in the overall infection interest process of the second of the seco	ential rough e Log oths ults y; ents. s le r lled if l at nurse neets in the oth ed and	21373				
	or left blank.	/00/40 at 40:40 !!	_					
	During interview on 5	/22/13, at 12:12 p.m. th	ie					

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/		` '	CONSTRUCTION	(X3) DATE	SURVEY
				A. BUILDING: _			
		00754		B. WING		05	/22/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-	
ADAMS H	EALTH CARE CENTER		810 WEST ADAMS, M	MAIN STREET N 55909	Г		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
21375	infection control nurse indicated employees each			21375			
	infection control nurse indicated employees each had an individual attendance record but verified there had been no tracking and trending of employee infections and how this may affect the residents acquiring infections or how the facility could educate staff to prevent the spread of infections through education.						
	During interview on 5/22/13, at 1:01 p.m. the director of nursing (DON) verified infection tracking forms were not completed to track and trend. The DON indicated staff does not tell us						
	why they call in so no	t able to track and trend someone comes in sic	d.				
	review dated 2008, it federal regulation land control program and of separate record of inf resident with an infect infection, causative and infection and described measures were taken	directed staff to maintain the cetion that identified eation, stated the date of gent, the origin or site of the date of the cet what cautionary in the facility. There was to prevent the spread in the facility. There was	e n a ach the of				
	Suggested Method of Correction: The director of nursing or her designee could review policy and procedures regarding infection control program. The director of nursing or her designee could educate staff on policy and procedures and develop a monitoring system to ensure compliance with surveillance analysis and trending was completed.						
	Time Period for Corredays.	ection: Twenty one (21)				

Minnesota Department of Health

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMB	ER:	A. BUILDING: _		COMF	PLETED
		00754		B. WING		05	/22/2013
NAME OF PRO	VIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
ADAMS HE	ALTH CARE CENTER		810 WEST ADAMS, M	MAIN STREET N 55909	Т		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
	A. The drug regimer reviewed at least mor currently licensed by this review must be of Appendix N of the State Surveyor Procedures Requirements in Long the Department of He Health Care Financing This standard is inconvailable through the system. It is not subjue B. The pharmacisi irregularities to the direct and the attending phymust be acted upon be physician visit, or soo pharmacist. For purpupon means the according of nursing services are C. If the attending with the pharmacist's not provide adequate pharmacist believes the being adversely affect refer the matter to the if the medical director physician. If the medical director physician does not change the interest of the attending physician does not change the referred for massessment and assuby part 4658.0070. If	the Board of Pharmacy done in accordance with the Operations Manual, for Pharmaceutical Sergarerm Care, published alth and Human Service alth and Human Service Gadministration, April proporated by reference. Minitex interlibrary load ect to frequent change. It must report any rector of nursing service exician, and these report by the time of the next ner, if indicated by the coses of this part, "acted eptance or rejection of the operation of the operation of the extending physician does not concommendation, or do justification, and the the resident's quality of the technique in the attending ical director determines and one of the extending in the attending lange the order, the manual eview to the quality urance committee requisiting pharmace directly to the quality of the detection of the extending physician does not have adequated and if the attending lange the order, the manual extending physician does not the quality urance committee requisiting pharmace directly to the quality the attending physician directly to the quality	be rvice d by es, 1992. It is n es rts d the ector ian. oncur oes life is st view s that uate atter red n is	21530			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			l ' '	CONSTRUCTION	(X3) DATE COMP	SURVEY		
		00754		B. WING		05/	/22/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	DDRESS, CITY, STATE, ZIP CODE				
ADAMS H	EALTH CARE CENTER		810 WEST ADAMS, M	MAIN STREET N 55909	Г			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FU		ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
21530	Continued From page	e 5		21530				
	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)							

Minnesota Department of Health

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Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00754		B. WING		05/	22/2013
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
ADAMS H	EALTH CARE CENTER		810 WEST ADAMS, M	MAIN STREET N 55909	г		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21530	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 impairment with some recall issues and had occasional mild pain. Physician orders dated 5/14/2013 were reviewed. The resident was prescribed Tramadol HCL (Ultram) 50 mg every 4 hours as needed for pain. Medication sheets and progress notes for 3/13, 4/13, and 5/13 were reviewed. The following was noted for the as needed Tramadol pain medication use: Tramadol was given on 5/13, 5/16, 5/19 however; nothing was documented regarding the reason it was given or the pain intensity, if effective, or what non- pharmacological interventions had been used. Tramadol was given on 4/19 related to nose clots causing anxiety; 4/20 requested a pill to "calm down"; 4/22 however, no indication for use given; 4/25 "too nervous to sleep." Tramadol was given on 3/2013: 3/2, 3/4, 3/10, 3/11, 3/15, 3/16, 3/20, 3/22, 3/25, all these dates lacked indication the medication was given nor was there any information as to pain intensity, if effective for pain relief or if non- pharmacological interventions had been used prior to the use of the pain medication. Tramadol given on 3/28 for complained of "nervousness" requesting something to aid sleep. Monthly pharmacy reviews dated 9/14/2012 through 5/15/2013 were reviewed. The reviews did not identify any issues with the use of the prn Tramadol being used for none pain related		21530				

Minnesota Department of Health

l ' '		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME		l ` ′	CONSTRUCTION	(X3) DATE	SURVEY	
7.1.5 . 2		.52		A. BUILDING: _				
		00754		B. WING		05/	/22/2013	
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	ADDRESS, CITY, STATE, ZIP CODE				
ADAMS H	EALTH CARE CENTER		810 WEST ADAMS, M	MAIN STREET N 55909	Г			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
21530	Physician notes reviewed: 5/15/2013 and comments that R9's pain is adequately controlled on current regime. On 5/22/2013 at 12:30 p.m., a registered nurse (RN)-D was interviewed regarding use of the Tramadol prn pain medication. RN-D said that the effectiveness of the pain medication should be documented after each time the resident receives the Tramadol. After reviewing March, April and May 2013 medication record for when Tramadol was given to R9 there were several incidents of no documentation for indication for use and if the medication was effective or not. On 5/22/2013 at 12:55 p.m., RN-D stated R9's family (F)-A will not let the staff use an antianxiety medication but F-A was okay with the tramadol being used as an antianxiety medication. However, there is no physician order for Tramadol to be used for anxiety. On 5/22/2013 at 1:45 p.m., the director of nursing (DON) was questioned about the use of Tramadol for R9 and she said it was used for pain, as well as other pain medications the resident was on for pain control. As far as the		21530					
	use and if the medication was effective for pain control the DON said the staff should be documenting in nursing notes when as needed pain medications are given. The DON indicated the Tramadol was given for pain and not to be used for anxiety symptoms as the physician had not given orders to use the Tramadol for anxiety.							
	R23 was on Clonazepam an antianxiety medication without clinical justification and rationale for continued use.							
	Physician orders date	ed 4/17/2013 were revie	ewed.					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE AND PLAN OF CORRECTION IDENTIFICATION NUM			l ` ′	CONSTRUCTION	(X3) DATE COMP	SURVEY	
				A. BUILDING: _			
		00754		B. WING		05/	/22/2013
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
ADAMS H	EALTH CARE CENTER		810 WEST ADAMS, M	MAIN STREET N 55909	Г		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
21530	R23 currently was pre (antianxiety) medicating Monthly pharmacy re 12/10/2012 through 5 dated 3/20/13 noted 6 medication was decreased to twice a day. Pl 0.25 mg at either a.m. If a reduction is not a clinical rationale. The documented "no char on 3/21/2013. However the justification as to Clonazepam was not nor was there any off the Clonazepam was. Clonazepam effective requested from 2/201 However, no monitoring February to May 2013. Medical doctors program 3/20/2013, 2/20/2013 the notes addressed of the Clonazepam m. On 5/21/2013 at 1:05 clinical care coordinate was interviewed. She anxiety disorder. RN came to the facility for anxious about returning RN-A verified R9 has symptoms/behaviors four months. RN-A all	views were reviewed dis/15/2013. A pharmacy on 12/12 clonazepam eased from three times lease consider tapering or p.m. dose if approper appropriate, please documentation assistant (Finge" to the recommended at this time. The recommended at this the recommended at this time. The recommended at this the recommended at this time. The recommended at this the recommended at this time. The recommended at this the recommended at this time. The recommended at this the recommended at this time.	ated y note a y by priate. ument PA) dation uded time to why te. a 2013, te of teness RN)-A ting an ly yas ng. st n and	21530			

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00754		B. WING		05/	/22/2013	
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE			
ADAMS H	EALTH CARE CENTER		810 WEST ADAMS, M	MAIN STREET N 55909	Г			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
21530	Continued From page 9			21530				
	medication to induce R8 was admitted to the diagnoses including: history of psychosis. Current physician order for tablet by mouth every date of 10/7/11. Further review of the Trazodone was started sleep assessment to causes of a sleep pronon-pharmacological sleep. Also there was monitoring of sleep qualities SLEEP policy dated 5/12/11 to the purpose was to gate for a base line of all rebut had not addresse assessment should be who has a dx of sleep medication to enhance On 5/21/13, at 10:54 (RN)-B was interview no sleep assessment a.m., RN-B identified had been completed comprehensive sleep completed for R8. During interview on 5 director of nursing (Do Trazodone was not us depression. The DON tool was utilized in the	of the hypnotic (Trazod sleep. The facility in 3/3/04 with vascular dementia with vascular demential value of the value of val	noted one a start ed a tial eg to EET fied sion notics sident e was 1:35 eet a					

Minnesota Department of Health STATE FORM

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Minnesota Department of Health

, , ,		(X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE S COMPL	
		00754		B. WING		05/2	22/2013
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, STA	ATE, ZIP CODE		
ADAMS H	EALTH CARE CENTER		810 WEST ADAMS, M	MAIN STREET IN 55909	Т		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	Continued From page	e 10		21530			
	physician had identified R8 had a sleep wake cycle and referenced the Trazodone to aid in better sleep.						
	R7 had pulse greater updated the physiciar	than 110 and staff had n.	not				
	R7 had diagnoses that included hypertension and atrial fibrillation. R7 had physician order for Metoprolol (Metoprolol is a beta-adrenergic blocking agent that is used for treating high blood pressure, heart pain, abnormal rhythms of the and some neurologic conditions.) 100 mg extended release take one tablet by mouth daily-call if pulse if over 110.						
	pulse greater than 11 physician had not bee order. On 1/21/13 pul	e documentation R7 ha 0 four times and the en notified per the phys se was 129 and 115, o , 2/22/13 126 and 4/9/1	ician n				
	During review of the Change in a Resident's Condition or Status policy dated 8/9/11, the policy directed the charge nurse would notify the resident's physician or on-call physician when there had been instructions to notify the physician of changes in the resident's condition.		policy en				
	During interview on 5/22/13 at 12:04 p.m. licensed practical nurse admission coordinator verified physician had not been notified of elevated pulse on each episode and the current order was to update the physician.						
	was not sure how the physician order to be	/22/13 at 1:18 p.m. DO staff had missed the updated if pulse above expected licensed star	110.				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00754						
		00754		B. WING		05/2	2/2013
NAME OF PR	ROVIDER OR SUPPLIER			RESS, CITY, STA	,		
ADAMS H	EALTH CARE CENTER		810 WEST ADAMS, MI	MAIN STREET N 55909			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21530	Continued From page	e 11		21530			
	follow the physician order as written and update when greater than 110 beats per minute.						
	R28 lacked a clinical rationale as to why a taper of an antidepressant had not been completed.						
	R28 was admitted to facility on 5/20/11 with diagnoses of dementia and depression. R28 had physician order for Celexa (antidepressant) 10 mg take one tablet by mouth daily. Last change with the Celexa was 10/7/11.						
	During interview on 5/22/13, at 1:15 p.m. DON indicated a note had been made on 4/23/12 regarding not changing the Celexa dosage and verified there had not been any documentation done since as to why a taper would not be indicated.						
	During interview on 5 registered nurse (RN) that there was no faci medications.	-C informed this survey	yor				
	SUGGESTED METHOD FOR CORRECTION: The administrator, director of nursing and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Staff could be educated as necessary. The director of nursing or designee could monitor medications on a regular basis to ensure compliance with state and federal regulations.						
	TIME PERIOD FOR CORRECTION: Twenty one (21) days.		y one				
21535	MN Rule4658.1315 S Drug Usage; General	ubp.1 ABCD Unnecess	sary	21535			

Minnesota Department of Health

, ,		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		l ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
00754				B. WING 05			22/2013	
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	1 00.1		
ADAMS H	EALTH CARE CENTER		810 WEST ADAMS, M	MAIN STREET N 55909	Г			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
21535	must be free from unrunnecessary drug is a A. in excessive d drug therapy; B. for excessive of C. without adequed D. in the presence which indicate the dodiscontinued. In addition to the drug part 4658.1310, the rewith provisions in the Code of Federal Regulations Manual, Coperations M	A resident's drug regine necessary drugs. An any drug when used: ose, including duplicate duration; ate indications for its use of adverse consequences should be reduced of gregimen review requinursing home must confinterpretive Guidelines allations, title 42, section pendix P of the State Guidance to Surveyors filities, published by the and Human Services, gadministration, April apporated by reference. Minitex interlibrary loar Law Library. It is not lange. It is not met as evidence wand interview the fandication for use of as adol pain medication promotion and/or failed to assess as effective in relieving (19); failed to provide cling) for the continued use in for 1 of 10 residents (19) and of an elevated pulse or 1 of 10 residents (19) and of an elevated pulse or 1 of 10 residents (19) and 19 or	se; or ences or red in apply for on for list is a red in acility rior to s if g pain acility of an (R23); of a R8);	21535				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEF AND PLAN OF CORRECTION IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
				A. BUILDING				
		00754		B. WING		05/	22/2013	
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	ADDRESS, CITY, STATE, ZIP CODE				
ADAMS H	EALTH CARE CENTER		810 WEST ADAMS, M	MAIN STREET N 55909	Т			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
21535	5 Continued From page 13			21535				
21535	medication to control clinical justification for antidepressant for more residents (R28) who residents review. Findings include: R9 lacked documents management includin reason/pain intensity, and use of other non-interventions used. A medication was some symptoms without a properties of the resident was president was p	heart rate; failed to pro- r continued use an one than one year for 1 received Celexa. All the during the unnecessary ation related to pain ag identification of the effectiveness of medical pharmacological also, the as needed pain etimes used for anxiety obysician order. Initial interview on 5/19/d pain in the shoulder a num Data Set (MDS) dinitive status as moderate recall issues and had	of 10 ese cation, n (2013 rea. ated te	21535				
	Medication sheets and progress notes for 3/13, 4/13, and 5/13 were reviewed. The following was noted for the as needed Tramadol pain medication use:		13,					
	Tramadol was given on 5/13, 5/16, 5/19 however; nothing was documented regarding the reason it was given or the pain intensity, if effective, or what non- pharmacological interventions had been used.							
	Tramadol was given o	on 4/19 related to nose	clots					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER				A. BUILDING: _			
00754				B. WING		05/2	2/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
ADAMS H	EALTH CARE CENTER		810 WEST ADAMS, M	MAIN STREET N 55909	Г		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FU		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
21535	PROVIDER OR SUPPLIER HEALTH CARE CENTER STREET AI 810 WES ADAMS, SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		0, ates for y, if gical of 8 for ews e prn ed rse hat uld h, nen al for ot. On	21535	DETICIENCY		
	being used as an anti	anxiety medication.					

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		` ′	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
				A. BUILDING: _				
		00754		B. WING		05/	22/2013	
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	ADDRESS, CITY, STATE, ZIP CODE				
ADAMS H	EALTH CARE CENTER		810 WEST ADAMS, M	BT MAIN STREET MN 55909				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE	
21535	Continued From page Tramadol to be used On 5/22/2013 at 1:45 (DON) was questioned Tramadol for R9 and pain, as well as other resident was on for palack of consistent docuse and if the medical control the DON said documenting in nursing pain medications are the Tramadol was give used for anxiety symphot given orders to use R23 was on Clonazer medication without clirationale for continued Physician orders date R23 currently was present a currently was decreased as a c	for anxiety. p.m., the director of nucled about the use of she said it was used for pain medications the ain control. As far as the cumentation for indication was effective for puthe staff should be not not	ursing or ee oon of ain led obe had kiety. ewed. ated or note a by oriate. ument or A) e PA	21535		AFFROFRIATE		
	recommended at this	time nor was there any as to why the Clonazer						

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	IDENTIFICATION NOME	EN.	A. BUILDING: _		COMP	LETED	
		00754		B. WING		05	/22/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	·		
ADAMS H	EALTH CARE CENTER		810 WEST ADAMS, M	T MAIN STREET MN 55909				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
21535	5 Continued From page 16			21535				
	Clonazepam effectiveness monitoring was requested from 2/2013 through 5/21/2013. However, no monitoring was completed from February to May 2013.							
	Medical doctors progress notes dated 4/17/2013, 3/20/2013, 2/20/2013, were reviewed. None of the notes addressed the use and/or effectiveness of the Clonazepam medication for anxiety.							
	On 5/21/2013 at 1:05 p.m. and 1:30 p.m., a clinical care coordinator -registered nurse (RN)-A was interviewed. She identified R23 as having an anxiety disorder. RN-A said that R9 originally came to the facility for short term stay and was anxious about returning back to assisted living. RN-A verified R9 hasn 't had any anxiety symptoms/behaviors documented for the past four months. RN-A also verified the physician and the PA had not documented a justification as to why a tapering of the Clonazepam was							
	R8 was not comprehensively assessed for insomnia prior to use of the hypnotic (Trazodone) medication to induce sleep. R8 was admitted to the facility in 3/3/04 with diagnoses including: vascular dementia with history of psychosis. Current physician orders were reviewed. It noted a physician order for Trazodone 50 mg take one tablet by mouth every night at bedtime with a start date of 10/7/11. Further review of the medical record, revealed Trazodone was started with no evidence of a sleep assessment to identify actual or potential causes of a sleep problem, or evaluate non-pharmacological intervention to promote sleep. Also there was no evidence of ongoing monitoring of sleep quality or hours of sleep to							

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB		l ` ´	CONSTRUCTION	(X3) DATE S		
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE			
ADAMS H	EALTH CARE CENTER		810 WEST ADAMS, M	ST MAIN STREET MN 55909				
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21535	Continued From page 17 determine if the medication was effective.			21535				
	The facilities SLEEP policy dated 5/12/11 of the purpose was to gate for a base line of all red but had not addressed assessment should be who has a dx of sleep medication to enhance On 5/21/13, at 10:54 of (RN)-B was interview no sleep assessment a.m., RN-B identified had been completed to comprehensive sleep completed for R8. During interview on 5 director of nursing (Down Trazodone was not us depression. The DON tool was utilized in the assessment was comphysician had identified cycle and referenced better sleep. R7 had pulse greater updated the physician R7 had diagnoses the atrial fibrillation. R7 had Metoprolol (Metoprolol blocking agent that is	PATTERNS FLOW SH was reviewed. It identification and admission and admission at the need for a sleep e completed on any responsion and verified there was a disturbance, uses the sleep. a.m., a registered nurse wed and verified there was completed for R8. At 1 a sleep pattern flow shoon 1/21/11 but verified assessment had been assessment had been with a sleep but for a lindicated the sleep pattern flow shoon 1/21/11 but no sleep pattern flow shoon 1/21/11 but verified the sed for sleep but for a lindicated the sleep pattern flow shoon and the sleep pattern flow shoon and the sleep pattern flow shoon and the sleep was the transport to aid in the sleep was the transport of the sleep was the transport of the sleep for the sleep for the sleep was the sleep for the sleep was the sleep sleep for the sleep	ried sion notics sident e was 1:35 eet a et e n not not nand blood					
		e documentation R7 ha	id a					

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NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	DDRESS, CITY, STATE, ZIP CODE				
ADAMS H	EALTH CARE CENTER		810 WEST ADAMS, MI	ST MAIN STREET MN 55909				
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21535	Continued From page 18			21535				
	physician had not been notified per the physician order. On 1/21/13 pulse was 129 and 115, on 2/19/13, 115 and 118, 2/22/13 126 and 4/9/13 was 113.							
	During review of the Change in a Resident's Condition or Status policy dated 8/9/11, the policy directed the charge nurse would notify the resident's physician or on-call physician when there had been instructions to notify the physician of changes in the resident's condition.							
	During interview on 5/22/13 at 12:04 p.m. licensed practical nurse admission coordinator verified physician had not been notified of elevated pulse on each episode and the current order was to update the physician.							
	was not sure how the physician order to be The DON would have	updated if pulse above expected licensed stated rder as written and upd	110. ff to					
		rationale as to why a ta had not been completed						
	R28 was admitted to facility on 5/20/11 with diagnoses of dementia and depression. R28 had physician order for Celexa (antidepressant) 10 mg take one tablet by mouth daily. Last change with the Celexa was 10/7/11.							
	with the Celexa was 10/7/11. During interview on 5/22/13, at 1:15 p.m. DON indicated a note had been made on 4/23/12 regarding not changing the Celexa dosage and verified there had not been any documentation done since as to why a taper would not be indicated.							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM				CONSTRUCTION	(X3) DATE S COMPL			
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21535	Continued From page 19			21535				
	During interview on 5/22/13 at 2:23 p.m. registered nurse (RN)-C informed this surveyor that there was no facility policy for tapering medications.							
	SUGGESTED METHOD FOR CORRECTION: The pharmacist/physician or director of nursing could in-service all staff who administer medications the need to monitor for irregularities such as lack of indication, medication effectiveness monitoring, gradual dose reduction or tapering of medications per federal regulations under F371.							
	TIME PERIOD FOR (21) days.	CORRECTION: Twent	y one					
21565	MN Rule 4658.1325 S Medications Self Adm	Subp. 4 Administration nin	of	21565				
	Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician.							
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 4 of 4 residents (R3, R17, R27 and R29) were assessed to safely self-administer medication through a nebulizer treatment.							
	Findings include:							

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` '		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		1 ' '	(X3) DATE SURVEY COMPLETED		
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NAME OF PE	ROVIDER OR SUPPLIER	***************************************	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	1 00/			
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21565	Continued From page 20			21565					
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 During observations on 5/21/13, at 1:05 p.m. R3, R17, R27 and R29 were observed in their rooms lying in bed with nebulizer mask over nose and mouth with nebulizer solution being dispensed. No licensed staff was observing to be present in any of these four rooms or in the halls outside these four rooms. During the observation licensed practical nurse (LPN)-A came down the hallway and said that she had been filling portable oxygen tanks (the oxygen filling room was located on another area of the facility) while residents were lying down. R3's diagnoses included but not limited to chronic obstructive pulmonary disease, hemiplegia and depression. R3's annual Minimum Data Set (MDS) dated 2/24/13 indicated cognitive impairment, had shortness of breath or trouble breathing when lying flat and required extensive to total assist for all activities of daily living (ADL's.) During review of the R3's medical record they included a current physician order dated 1/27/12, DuoNeb (medication used to clear the bronchi) 2.5 milligrams (mg) - 0.5 mg in 3 milliliter (ml) solution four times a day (QID) which was delivered to the resident through the use of a nebulizer inhalant treatment. Further review of the medical record revealed ASSESSMENT TOOL FOR RESIDENT SELF-ADMINISTRATION OF MEDICATIONS dated 3/20/12, indicated the resident had been assessed and was unable to safely self-administer medications which also included								

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE AND PLAN OF CORRECTION IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION		(X3) DATE :		
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	chronic airway obstruction, asthma and Alzheimer's disease.						
	R17's quarterly MDS dated 2/16/13 indicated cognitive impairment, and required extensive assist for all ADL's.						
	During review of the R17's medical record they included current physician order dated 10/7/11, DuoNeb 2.5 mg - 0.5 mg in 3 ml solution QID. Further review of the medical record revealed ASSESSMENT TOOL FOR RESIDENT SELF-ADMINISTRATION OF MEDICATIONS dated 7/19/11, indicated the resident had been assessed and was unable to safely self-administer medications. The assessment identified due to cognitive status it would not be realistic for her to dispense own respiratory medication.						
	R27's diagnoses incluanxiety, depression, a coughing.	uded but not limited to and labored respiration	and				
	R27's annual MDS da cognitive impairment, total assist for all ADL	and required extensive	e to				
	During review of the R27's medical record they included current physician order dated 4/8/13, DuoNeb 2.5 mg - 0.5 mg in 3 ml solution every four hours while wake. Further review of the medical record revealed no current ASSESSMENT TOOL FOR RESIDENT SELF-ADMINISTRATION OF MEDICATIONS. R29's diagnoses included but not limited to						
	respiratory failure.	1.4.10/=//2.1					
	R29's quarterly MDS	dated 2/7/13 indicated					

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21565	PROVIDER OR SUPPLIER HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		21565					
	each resident had the	right to self-administer						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEI IDENTIFICATION NUM			` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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ADAMS H	EALTH CARE CENTER		810 WEST ADAMS, M	MAIN STREET N 55909	Т		
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21565	Continued From page	23		21565			
	determined that the practice is unsafe. The policy indicated residents have the right to defer responsibility to the facility. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review and revise the policies and procedures for the resident self-administration of medication assessment/protocol and care plan, educate the appropriate personnel in any changes and appoint a designee to monitor the procedures to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.						
21942	days. MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview the facility failed to make an attempt to form a family council on an annual basis. Findings include:		21942				
	_	t 8:46 a.m. on 5/21/13, r (LSW) stated she sta	rted				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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21942	,		21942				
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section.		21995				

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		(X1) PROVIDER/SUPPLIER/		` ′	CONSTRUCTION	(X3) DATE	SURVEY
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	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to report allegations of verbal abuse, neglect and mistreatment immediately to the designated state agency (Office of Health & Facility Complaints [OHFC] division of Minnesota Department of Health-MDH) for 3 of 5 residents (R20, R6, R43) reviewed for abuse prohibition. Findings include: R20 had an allegation of verbal abuse on 12/20/12 however; OHFC had not been notified until the next day on 12/21/12.						
	R6 had an allegation of neglect on 4/2/13 however; OHFC had not been notified until 4/4/13 which was two days after incident was found. R43 had an allegation of mistreatment on 3/18/13 however; OHFC had not been notified until the next day which was on 3/19/13. When interviewed at 8:46 a.m. on 5/21/13, the licensed social worker (LSW) stated upon discovery of a concern or complaint (allegation), staff are to ensure the resident was safe and all needs were met prior to leaving the resident. The next step was for staff to report the concern to the wing nurse if staff could find them. If staff cannot find their wing nurse they are to come to LSW or director of nursing (DON). The administrator was to be immediately informed and from there, the LSW gathered all information to make the first report to OHFC. LSW stated as soon as she had all the information needed, she made the report immediately. The LSW stated it had never been more than ten to fifteen minutes after LSW had been made aware of a vulnerable adult concern before the initial report was made to OHFC on the						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		1 ' '	(X3) DATE SURVEY COMPLETED	
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21995	computer. On reviewing and R43 with the facility staff had failed suspected abuse or madministrator, DON and immediately and the ladult reports complete were not made to the director of nursing (Downs all incidents of sumistreatment must be administrator, DON, and immediately and a regimmediately to OHFC facility staff failed to mabuse or mistreatment and social services in R43 and verified that completed for R20, R to the OHFC immediately and a regimmediately and a regimmediately to OHFC facility staff failed to mabuse or mistreatment and social services in R43 and verified that completed for R20, R to the OHFC immediately incident an undated punitial report must be facility administrator, social worker and MD as soon as possible, hours after discovery SUGGESTED METH The administrator, DC designee(s) could revinecessary the policies the internal process of abuse or madministrator, DON, so	ng the allegations for RLSW the LSW verified of the report incidents of inistreatment to the and social services. SW verified the vulner ed for R20, R6, and R4 OHFC immediately. It 11:32 a.m. on 5/22/13 ON) stated her expectal aspected abuse or expected immediately to the director of nursing, or expected immediately to the director of nursing, or expected immediately to the director of nursing, or expected immediately means abut ought not to exceed of the incident. " OD FOR CORRECTION, social services or designal freporting/investigating and revise as and procedures regard freporting/investigating and procedures or designal for all appropriate signing for all appropriates."	able and able ation and ports ade able the ans ade able the ans ade able the ans ade able the ans ade able ans add able and able and able and able and able able and able and able able and able able and able able able able able able able able	21995				

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	(s) could monitor to a are being reported an	social services or desig ssure all reports of abu nd investigated. CORRECTION: Twent	se					
22000				22000				
	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.							
	and personal care att	cept home health agen endant services provide able adult has committed	ers,					

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		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
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	facility failed to follow their policy to report allegations of verbal abuse, neglect and mistreatment of residents to the administrator, director of nursing and social worker immediately and the facility failed to report immediately to designated state agencies (Office of Health Facility Complaints [OHFC] a division of Minnesota Department of Health [MDH]) for 3 of 5 residents (R20, R6, R43) reviewed for abuse prohibition. Findings include: R20 had an allegation of verbal abuse on 12/20/12 however; OHFC had not been notified until 12/21/12. R6 had an allegation of neglect on 4/2/13 however; OHFC had not been notified until 4/4/13.							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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22000	Continued From page	29		22000			
	R43 had an allegation of mistreatment on 3/18/13 however; OHFC had not been notified until 3/19/13.						
	Review of the Reporting a Vulnerable Adult Incident undated policy, instructed staff the initial report must be reported immediately to the facility administrator, the director of nursing, the social worker and MDH. "Immediately means as soon as possible, but ought not to exceed 24 hours after discovery of the incident."						
	When interviewed at 8:46 a.m. on 5/21/13, the licensed social worker (LSW) verified the facility staff failed to follow the policy to report incidents of suspected abuse or mistreatment to the administrator, DON and social worker immediately for R20, R6 and R43 and verified the vulnerable adult reports completed for R20, R6, and R43 were not made to the OHFC immediately.						
	When interviewed at 11:32 a.m. on 5/22/13 the director of nursing (DON) verified the Reporting a Vulnerable Adult Incident undated policy, instructed staff the initial report must be reported immediately to the facility administrator, the director of nursing, the social worker and MDH. "Immediately means as soon as possible, but ought not to exceed 24 hours after discovery of the incident." The DON verified the facility staff failed to report incidents of suspected abuse or mistreatment to the administrator, DON and social services immediately for R20, R6 and R43 and verified the vulnerable adult reports completed for R20, R6, and R43 were not made to the OHFC immediately.						
	SUGGESTED METH	OD FOR CORRECTIO	N:				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
				A. BOILDING.			
00754		B. WING 05/22/2013			22/2013		
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
ADAMS H	EALTH CARE CENTER		810 WEST ADAMS, M	MAIN STREET N 55909	Г		
(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 C (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETE DATE
22000	Continued From page	e 30		22000			
22000	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		22000				