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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 9KQN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00754

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245509**
2.STATE VENDOR OR MEDICAID NO.
(L2) **015540300**

3. NAME AND ADDRESS OF FACILITY
(L3) **ADAMS HEALTH CARE CENTER**
(L4) **810 WEST MAIN STREET**
(L5) **ADAMS, MN** (L6) **55909**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 07/08/2013 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **54** (L18)

13.Total Certified Beds **54** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective June 12, 2013, the facility is certified 54 for skilled nursing facility beds.

17. SURVEYOR SIGNATURE — Date :
Gary Nederhoff, Unit Supervisor 09/09/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Colleen B. Leach, Program Specialist 12/20/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/25/2013
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 Leach

Colleen B. Leach, Program Specialist
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

cc: Licensing and Certification File

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245509	A. Building B. Wing	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
ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **06/12/2013**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **06/12/2013**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **06/12/2013**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **06/12/2013**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **06/12/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **06/12/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/GPN	07/09/2013	10160	07/08/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/22/2013			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9KQN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00754

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245509**

2.STATE VENDOR OR MEDICAID NO.
(L2) **015540300**

3. NAME AND ADDRESS OF FACILITY
(L3) **ADAMS HEALTH CARE CENTER**
(L4) **810 WEST MAIN STREET**
(L5) **ADAMS, MN** (L6) **55909**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/22/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **54** (L18)

13.Total Certified Beds **54** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

At the time of the May 22, 2013 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Robin Lewis, HFE NEII 06/18/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 07/18/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 7/25/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245509	A. BUILDING _____ B. WING _____ JUN 14 2013 MN Dept of Health Perhaps	05/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS HEALTH CARE CENTER	810 WEST MAIN STREET ADAMS, MN 55909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Please note that our signature and the response on the CMS-2567L does not mean that we agree with either the tagged deficiency or the evidence presented to support any determination of non-compliance. We respond and provide a written plan of correction because the law requires it.	
F 176 SS=E	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This 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: During observations on 5/21/13, at 1:05 p.m. to 1:07 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	F 176	• Per Adams Health Care Center's policy, the nursing staff will administer all medications to residents who defer the responsibility to the facility and will allow resident to self-administer medications unless the interdisciplinary team determined that the practice is unsafe. • An in-service education was held on June 12, 2013 for all licensed nurses and TMA's to review policy and procedure for the resident self-administration of medication assessment/protocol and care plan. • Random audits will be conducted once per week for 1 month and once per month for 3 months.	6-18-13 SPN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Georgette Hamble — TITLE: ADMINISTRATOR — (X6) DATE: 6/13/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245509	A. BUILDING _____ B. WING _____ JUN 14 2013	05/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS HEALTH CARE CENTER	810 WEST MAIN STREET ADAMS, MN 55909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	Continued From page 1 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 inhalant medication. R17's diagnoses included but not limited to 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.	F 176	• The Director of Nursing, the Staff Development and/or their designee are responsible to monitor for compliance. Results will be reported monthly to the Quality Improvement Committee for review and/or further recommendations.	6/12/13

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F 176	Continued From page 2 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 included but not limited to anxiety, depression, and labored respiration and coughing. R27's annual MDS dated 2/12/13 indicated cognitive impairment, and required extensive to total assist for all ADL's. 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. R29's quarterly MDS dated 2/7/13 indicated moderate cognitive impairment, and required extensive to total assist for all ADL's. During review of the R29's medical record they	F 176		

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F 176	Continued From page 3 included current physician order dated 4/29/13, DuoNeb 2.5 mg - 0.5 mg in 3 ml solution QID. Further review of the medical record revealed R29 chose to have facility responsible for administering all medication. During interview on 5/21/13, at 1:07 p.m. LPN-A verified R3, R17, R27 and R29's nebulizer medication treatment had been set-up for these four residents and then each residents had been left alone while the medication treatment was running. LPN-A stated, "We hook them [resident] up and go back in to monitor while they're on it." LPN-A further verified R3, R17, R27 and R29 were unable to self-administer medication and was unaware if self-administration of medication assessments had been completed for R3, R17, R27 and R29. During interview on 5/21/13, at 1:15 p.m. the director of nursing (DON) reported all residents require self-administer of medication assessment to be completed before they can be left alone with nebulizer medication treatment. During interview on 5/22/13, at 9:45 a.m. DON verified no current self-administration of medication assessment had been found in R27's medical record. DON further verified R3, R17, R27 and R29 were unable to self-administer medication which also included inhalants. Review of SELF-ADMINISTRATION OF MEDICATION policy dated 3/28/13, revealed each resident had the right to self-administer drugs unless the interdisciplinary team has determined that the practice is unsafe. The policy indicated residents have the right to defer	F 176		

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F 176	Continued From page 4 responsibility to the facility.	F 176		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	• Adams Health Care Center staff will report allegations of verbal abuse, neglect and mistreatment immediately to the administrator of the facility and to other officials (OHFC, CEP) in accordance with State Law through established procedures. • Training provided on June 12, 2013 for all staff to review the policy and procedure for internal process of reporting/investigating the process of abuse or maltreatment. • The Administrator, Social Services and/or their designee will monitor to assure all reports of abuse are being reported and investigated timely.	6/12/13

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F 225	Continued From page 5 This 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	F 225		

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F 225	Continued From page 6 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 computer. On reviewing the allegations for R20, R6 and R43 with the LSW the LSW verified the facility staff had failed to report incidents of suspected abuse or mistreatment to the administrator, DON and social services immediately and the LSW verified the vulnerable adult reports completed for R20, R6, and R43 were not made to the OHFC immediately. During an interview at 11:32 a.m. on 5/22/13 the director of nursing (DON) stated her expectation was all incidents of suspected abuse or mistreatment must be reported to the administrator, DON, and social services immediately and a report was to be completed immediately to OHFC. 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 that the vulnerable adult reports completed for R20, R6, and R43 were not made to the OHFC immediately. Review of the Reporting a Vulnerable Adult Incident an undated policy, instructed staff to: 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. "	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		

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F 226	Continued From page 7 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the 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. 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	F 226	• Adams Health Care Center staff will report allegations of verbal abuse, neglect and mistreatment immediately to the administrator of the facility and to other officials (OHFC, CEP) in accordance with State Law through established procedures. • Training provided on June 12, 2013 for all staff regarding reporting responsibilities and following the procedures of the Abuse Prevention and Vulnerable policies. • The Administrator, Social Services and/or their designee will monitor to assure all reports of abuse are being reported and investigated timely.	6/12/13

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F 226	Continued From page 8 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.	F 226		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose	F 329	• All medications irregularities, lack of indication, effectiveness, and gradual reduction or tapering are being monitored by the pharmacist, physician and director of nursing.	

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F 329	Continued From page 9 should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: During document review and interview the facility failed to identify the indication for use of as needed (PRN) Tramadol pain medication prior to giving the medication and/or failed to assess if the pain medication was effective in relieving pain for 1 of 10 resident (R9); failed to provide clinical rationale (justification) for the continued use of an antianxiety medication for 1 of 10 residents (R23); failed to ensure a comprehensive sleep assessment was completed prior to the use of a hypnotic medication for 1 of 10 residents (R8); failed to notify physician of an elevated pulse for 1 of 10 resident (R7) who received cardiac medication to control heart rate; failed to provide clinical justification for continued use an antidepressant for more than one year for 1 of 10 residents (R28) who received Celexa. All these	F 329	• In-service training provided on June 12, 2013 to licensed nursing staff who administer medications to monitor for irregularities, effectiveness, gradual dose reduction or tapering of medications. • The Director of Nursing, Staff Development and/or their designee are responsible to monitor for compliance.	6/12/13

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F 329	Continued From page 10 findings were found during the unnecessary medications review. Findings include: R9 lacked documentation related to pain management including identification of the reason/pain intensity, effectiveness of medication, and use of other non- pharmacological interventions used. Also, the as needed pain medication was sometimes used for anxiety symptoms without a physician order. R9 indicated, during initial interview on 5/19/2013 at 2:47 p.m., they had pain in the shoulder area. R9 ' s Quarterly Minimum Data Set (MDS) dated 3/31/2013 noted cognitive status as moderate 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	F 329		

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F 329	Continued From page 11 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 symptoms. Even though the physician ordered the Tramadol for pain control only. 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	F 329		

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F 329	Continued From page 12 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 lack of consistent documentation for indication of 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 dated 4/17/2013 were reviewed. R23 currently was prescribed Clonazepam (antianxiety) medication 0.5 mg twice a day. Monthly pharmacy reviews were reviewed dated 12/10/2012 through 5/15/2013. A pharmacy note dated 3/20/13 noted on 12/12 clonazepam medication was decreased from three times a day to twice a day. Please consider tapering by 0.25 mg at either a.m. or p.m. dose if appropriate. If a reduction is not appropriate, please document clinical rationale. The Physician assistant (PA) documented "no change " to the recommendation on 3/21/2013. However, the PA had not included the justification as to why a tapering of the Clonazepam was not recommended at this time nor was there any other documentation as to why the Clonazepam	F 329		

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F 329	Continued From page 13 was not tapered at this time. 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 contraindicated at this time. 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	F 329		

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F 329	Continued From page 14 non-pharmacological intervention to promote sleep. Also there was no evidence of ongoing monitoring of sleep quality or hours of sleep to determine if the medication was effective. The facilities SLEEP PATTERNS FLOW SHEET policy dated 5/12/11 was reviewed. It identified the purpose was to gather data on all admission for a base line of all residents receiving hypnotics but had not addressed the need for a sleep assessment should be completed on any resident who has a dx of sleep disturbance, uses medication to enhance sleep. On 5/21/13, at 10:54 a.m., a registered nurse (RN)-B was interviewed and verified there was no sleep assessment completed for R8. At 11:35 a.m., RN-B identified a sleep pattern flow sheet had been completed on 1/21/11 but verified a comprehensive sleep assessment had been completed for R8. During interview on 5/22/13, at 1:10 p.m. the director of nursing (DON) indicated the Trazodone was not used for sleep but for depression. The DON indicated the sleep pattern tool was utilized in the facility but no sleep assessment was completed. DON verified the physician had identified R8 had a sleep wake cycle and referenced the Trazodone to aid in better sleep. R7 had pulse greater than 110 and staff had not updated the physician. 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	F 329		

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F 329	Continued From page 15 extended release take one tablet by mouth daily-call if pulse if over 110. During review of pulse documentation R7 had a pulse greater than 110 four times and the 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. During interview on 5/22/13 at 1:18 p.m. DON was not sure how the staff had missed the physician order to be updated if pulse above 110. The DON would have expected licensed staff to 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.	F 329		

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F 329	Continued From page 16 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 5/22/13 at 2:23 p.m. registered nurse (RN)-C informed this surveyor that there was no facility policy for tapering medications.	F 329		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: During document review and interview the facility failed to act on the pharmacist recommendations for drug irregularities and/or the pharmacist failed to identify and report these irregularities to the physician and director of nursing for the following: Indication for use of as needed (PRN) Tramadol pain medication prior to giving the medication and/or failed to assess if the pain medication was effective in relieving pain for 1 of 10 resident (R9);	F 428	• All medications irregularities, lack of indication, effectiveness, and gradual reduction or tapering are being monitored by the pharmacist, physician and director of nursing. • In-service training provided on June 12, 2013 to licensed nursing staff who administer medications to review policy and procedure for proper medication usage. • The Director of Nursing, Staff Development and/or their designee are responsible to monitor for compliance on a regular basis.	6/12/13

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F 428	Continued From page 17 failed to provide clinical rationale (justification) for the continued use of an antianxiety medication for 1 of 10 residents (R23); failed to ensure a comprehensive sleep assessment was completed prior to the use of a hypnotic medication for 1 of 10 residents (R8); failed to notify physician of an elevated pulse for 1 of 10 resident (R7) who received cardiac medication to control heart rate; failed to provide clinical justification for continued use an antidepressant for more than one year for 1 of 10 residents (R28) who received Celexa. All these findings were found during the unnecessary medications review. Findings include: R9 lacked documentation related to pain management including identification of the reason/pain intensity, effectiveness of medication, and use of other non- pharmacological interventions used. Also, the as needed pain medication was sometimes used for anxiety symptoms without a physician order. R9 indicated, during initial interview on 5/19/2013 at 2:47 p.m., they had pain in the shoulder area. R9 ' s Quarterly Minimum Data Set (MDS) dated 3/31/2013 noted cognitive status as moderate 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	F 428		

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F 428	Continued From page 18 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 symptoms. Even though the physician ordered the Tramadol for pain control only. 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	F 428		

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F 428	Continued From page 19 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 lack of consistent documentation for indication of 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 dated 4/17/2013 were reviewed. R23 currently was prescribed Clonazepam (antianxiety) medication 0.5 mg twice a day. Monthly pharmacy reviews were reviewed dated 12/10/2012 through 5/15/2013. A pharmacy note dated 3/20/13 noted on 12/12 clonazepam	F 428		

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F 428	Continued From page 20 medication was decreased from three times a day to twice a day. Please consider tapering by 0.25 mg at either a.m. or p.m. dose if appropriate. If a reduction is not appropriate, please document clinical rationale. The Physician assistant (PA) documented "no change" to the recommendation on 3/21/2013. However, the PA had not included the justification as to why a tapering of the Clonazepam was not recommended at this time nor was there any other documentation as to why the Clonazepam was not tapered at this time. 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 contraindicated at this time. 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	F 428		

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F 428	Continued From page 21 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 determine if the medication was effective. The facilities SLEEP PATTERNS FLOW SHEET policy dated 5/12/11 was reviewed. It identified the purpose was to gather data on all admission for a base line of all residents receiving hypnotics but had not addressed the need for a sleep assessment should be completed on any resident who has a dx of sleep disturbance, uses medication to enhance sleep. On 5/21/13, at 10:54 a.m., a registered nurse (RN)-B was interviewed and verified there was no sleep assessment completed for R8. At 11:35 a.m., RN-B identified a sleep pattern flow sheet had been completed on 1/21/11 but verified a comprehensive sleep assessment had been completed for R8. During interview on 5/22/13, at 1:10 p.m. the director of nursing (DON) indicated the Trazodone was not used for sleep but for depression. The DON indicated the sleep pattern tool was utilized in the facility but no sleep assessment was completed. DON verified the physician had identified R8 had a sleep wake cycle and referenced the Trazodone to aid in better sleep.	F 428		

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F 428	Continued From page 22 R7 had pulse greater than 110 and staff had not updated the physician. 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. During review of pulse documentation R7 had a pulse greater than 110 four times and the 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. During interview on 5/22/13 at 1:18 p.m. DON was not sure how the staff had missed the physician order to be updated if pulse above 110. The DON would have expected licensed staff to follow the physician order as written and update	F 428		

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F 428	Continued From page 23 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 5/22/13 at 2:23 p.m. registered nurse (RN)-C informed this surveyor that there was no facility policy for tapering medications.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	• An infection control surveillance analysis and trending will be completed for residents and staff. • An in-service education will be held on June 12, 2013 to review policy/procedure and the monitoring system put in place to ensure compliance. • The Director of Nursing, Infection Control Nurse and/or their designee are responsible to monitor for compliance. Results are reported monthly to the Quality Improvement Committee for review and/or further recommendations.	6/12/13

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F 441	Continued From page 24 (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 by: 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.	F 441		

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F 441	Continued From page 25 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	F 441		

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F 441	Continued From page 26 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 not able to track and trend. The DON indicated if someone comes in sick they would send them home. During infection control program policy procedure review dated 2008, it included a review of the federal regulation language for an infection control program and directed staff to maintain a separate record of infection that identified each resident with an infection, stated the date of the infection, causative agent, the origin or site of infection and described what cautionary measures were taken to prevent the spread if the infection was present in the facility. There was no employee infection control program policy.	F 441		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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	00754	A. BUILDING: _____ B. WING _____	05/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Continued From page 1 Certification Program; 18 Wood Lake Drive SE, Rochester, MN 55904.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to develop and maintain a comprehensive infection control surveillance program for residents that included analysis of	21375		

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21375	Continued From page 2	21375		

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.

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

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21375	Continued From page 3 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 not able to track and trend. The DON indicated if someone comes in sick they would send them home. During infection control program policy procedure review dated 2008, it included a review of the federal regulation language for an infection control program and directed staff to maintain a separate record of infection that identified each resident with an infection, stated the date of the infection, causative agent, the origin or site of infection and described what cautionary measures were taken to prevent the spread if the infection was present in the facility. There was no employee infection control program policy. 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 Correction: Twenty one (21) days.	21375		

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21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.	21530		

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21530	Continued From page 5 This MN Requirement is not met as evidenced by: During document review and interview the facility failed to act on the pharmacist recommendations for drug irregularities and/or the pharmacist failed to identify and report these irregularities to the physician and director of nursing for the following: Indication for use of as needed (PRN) Tramadol pain medication prior to giving the medication and/or failed to assess if the pain medication was effective in relieving pain for 1 of 10 resident (R9); failed to provide clinical rationale (justification) for the continued use of an antianxiety medication for 1 of 10 residents (R23); failed to ensure a comprehensive sleep assessment was completed prior to the use of a hypnotic medication for 1 of 10 residents (R8); failed to notify physician of an elevated pulse for 1 of 10 resident (R7) who received cardiac medication to control heart rate; failed to provide clinical justification for continued use an antidepressant for more than one year for 1 of 10 residents (R28) who received Celexa. All these findings were found during the unnecessary medications review. Findings include: R9 lacked documentation related to pain management including identification of the reason/pain intensity, effectiveness of medication, and use of other non- pharmacological interventions used. Also, the as needed pain medication was sometimes used for anxiety symptoms without a physician order. R9 indicated, during initial interview on 5/19/2013 at 2:47 p.m., they had pain in the shoulder area. R9 ' s Quarterly Minimum Data Set (MDS) dated 3/31/2013 noted cognitive status as moderate	21530		

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21530	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 symptoms. Even though the physician ordered the Tramadol for pain control only.	21530		

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21530	Continued From page 7 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 lack of consistent documentation for indication of 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 dated 4/17/2013 were reviewed.	21530		

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21530	Continued From page 8 R23 currently was prescribed Clonazepam (antianxiety) medication 0.5 mg twice a day. Monthly pharmacy reviews were reviewed dated 12/10/2012 through 5/15/2013. A pharmacy note dated 3/20/13 noted on 12/12 clonazepam medication was decreased from three times a day to twice a day. Please consider tapering by 0.25 mg at either a.m. or p.m. dose if appropriate. If a reduction is not appropriate, please document clinical rationale. The Physician assistant (PA) documented "no change" to the recommendation on 3/21/2013. However, the PA had not included the justification as to why a tapering of the Clonazepam was not recommended at this time nor was there any other documentation as to why the Clonazepam was not tapered at this time. 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 contraindicated at this time.	21530		

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21530	Continued From page 9 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 determine if the medication was effective. The facilities SLEEP PATTERNS FLOW SHEET policy dated 5/12/11 was reviewed. It identified the purpose was to gather data on all admission for a base line of all residents receiving hypnotics but had not addressed the need for a sleep assessment should be completed on any resident who has a dx of sleep disturbance, uses medication to enhance sleep. On 5/21/13, at 10:54 a.m., a registered nurse (RN)-B was interviewed and verified there was no sleep assessment completed for R8. At 11:35 a.m., RN-B identified a sleep pattern flow sheet had been completed on 1/21/11 but verified a comprehensive sleep assessment had been completed for R8. During interview on 5/22/13, at 1:10 p.m. the director of nursing (DON) indicated the Trazodone was not used for sleep but for depression. The DON indicated the sleep pattern tool was utilized in the facility but no sleep assessment was completed. DON verified the	21530		

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21530	Continued From page 10 physician had identified R8 had a sleep wake cycle and referenced the Trazodone to aid in better sleep. R7 had pulse greater than 110 and staff had not updated the physician. 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. During review of pulse documentation R7 had a pulse greater than 110 four times and the 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. During interview on 5/22/13 at 1:18 p.m. DON was not sure how the staff had missed the physician order to be updated if pulse above 110. The DON would have expected licensed staff to	21530		

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21530	Continued From page 11 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 5/22/13 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 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.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General	21535		

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21535	Continued From page 12 Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: During document review and interview the facility failed to identify the indication for use of as needed (PRN) Tramadol pain medication prior to giving the medication and/or failed to assess if the pain medication was effective in relieving pain for 1 of 10 resident (R9); failed to provide clinical rationale (justification) for the continued use of an antianxiety medication for 1 of 10 residents (R23); failed to ensure a comprehensive sleep assessment was completed prior to the use of a hypnotic medication for 1 of 10 residents (R8); failed to notify physician of an elevated pulse for 1 of 10 resident (R7) who received cardiac	21535		

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21535	Continued From page 13 medication to control heart rate; failed to provide clinical justification for continued use an antidepressant for more than one year for 1 of 10 residents (R28) who received Celexa. All these findings were found during the unnecessary medications review. Findings include: R9 lacked documentation related to pain management including identification of the reason/pain intensity, effectiveness of medication, and use of other non- pharmacological interventions used. Also, the as needed pain medication was sometimes used for anxiety symptoms without a physician order. R9 indicated, during initial interview on 5/19/2013 at 2:47 p.m., they had pain in the shoulder area. R9 ' s Quarterly Minimum Data Set (MDS) dated 3/31/2013 noted cognitive status as moderate 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	21535		

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21535	Continued From page 14 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 symptoms. Even though the physician ordered the Tramadol for pain control only. 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	21535		

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21535	Continued From page 15 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 lack of consistent documentation for indication of 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 dated 4/17/2013 were reviewed. R23 currently was prescribed Clonazepam (antianxiety) medication 0.5 mg twice a day. Monthly pharmacy reviews were reviewed dated 12/10/2012 through 5/15/2013. A pharmacy note dated 3/20/13 noted on 12/12 clonazepam medication was decreased from three times a day to twice a day. Please consider tapering by 0.25 mg at either a.m. or p.m. dose if appropriate. If a reduction is not appropriate, please document clinical rationale. The Physician assistant (PA) documented "no change " to the recommendation on 3/21/2013. However, the PA had not included the justification as to why a tapering of the Clonazepam was not recommended at this time nor was there any other documentation as to why the Clonazepam was not tapered at this time.	21535		

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21535	Continued From page 16 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 contraindicated at this time. 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	21535		

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21535	Continued From page 17 determine if the medication was effective. The facilities SLEEP PATTERNS FLOW SHEET policy dated 5/12/11 was reviewed. It identified the purpose was to gather data on all admission for a base line of all residents receiving hypnotics but had not addressed the need for a sleep assessment should be completed on any resident who has a dx of sleep disturbance, uses medication to enhance sleep. On 5/21/13, at 10:54 a.m., a registered nurse (RN)-B was interviewed and verified there was no sleep assessment completed for R8. At 11:35 a.m., RN-B identified a sleep pattern flow sheet had been completed on 1/21/11 but verified a comprehensive sleep assessment had been completed for R8. During interview on 5/22/13, at 1:10 p.m. the director of nursing (DON) indicated the Trazodone was not used for sleep but for depression. The DON indicated the sleep pattern tool was utilized in the facility but no sleep assessment was completed. DON verified the physician had identified R8 had a sleep wake cycle and referenced the Trazodone to aid in better sleep. R7 had pulse greater than 110 and staff had not updated the physician. 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. During review of pulse documentation R7 had a pulse greater than 110 four times and the	21535		

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21535	Continued From page 18 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. During interview on 5/22/13 at 1:18 p.m. DON was not sure how the staff had missed the physician order to be updated if pulse above 110. The DON would have expected licensed staff to 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.	21535		

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21535	Continued From page 19 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. F332 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 CORRECTION: Twenty one (21) days.	21535		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin 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:	21565		

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21565	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 inhalant medication. R17's diagnoses included but not limited to	21565		

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21565	Continued From page 21 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 included but not limited to anxiety, depression, and labored respiration and coughing. R27's annual MDS dated 2/12/13 indicated cognitive impairment, and required extensive to total assist for all ADL's. 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. R29's quarterly MDS dated 2/7/13 indicated	21565		

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21565	Continued From page 22 moderate cognitive impairment, and required extensive to total assist for all ADL's. During review of the R29's medical record they included current physician order dated 4/29/13, DuoNeb 2.5 mg - 0.5 mg in 3 ml solution QID. Further review of the medical record revealed R29 chose to have facility responsible for administering all medication. During interview on 5/21/13, at 1:07 p.m. LPN-A verified R3, R17, R27 and R29's nebulizer medication treatment had been set-up for these four residents and then each residents had been left alone while the medication treatment was running. LPN-A stated, "We hook them [resident] up and go back in to monitor while they're on it." LPN-A further verified R3, R17, R27 and R29 were unable to self-administer medication and was unaware if self-administration of medication assessments had been completed for R3, R17, R27 and R29. During interview on 5/21/13, at 1:15 p.m. the director of nursing (DON) reported all residents require self-administer of medication assessment to be completed before they can be left alone with nebulizer medication treatment. During interview on 5/22/13, at 9:45 a.m. DON verified no current self-administration of medication assessment had been found in R27's medical record. DON further verified R3, R17, R27 and R29 were unable to self-administer medication which also included inhalants. Review of SELF-ADMINISTRATION OF MEDICATION policy dated 3/28/13, revealed each resident had the right to self-administer drugs unless the interdisciplinary team has	21565		

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21565	Continued From page 23 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.	21565		
21942	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: During an interview at 8:46 a.m. on 5/21/13, licensed social worker (LSW) stated she started	21942		

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21942	Continued From page 24 in May 2012 and was told the facility did not have a family council. LSW stated when the facility attempted to have family council meetings in the past there was not a good turnout and no interest by families. LSW verified there had been no attempt to initiate a family council since LSW started in May 2012. During an interview at 2:30 p.m. on 5/21/13 family member-A verified the facility had not attempted to form a family council. Family member- A required an explanation of what a family council was. During an interview at 11:32 a.m. on 5/22/13 the director of nursing verified in the last year there had been no attempt to form a family council. SUGGESTED METHOD OF CORRECTION: The administrator or designee will contact families and attempt to begin a family council. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	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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21995	Continued From page 25 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	21995		

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21995	Continued From page 26 computer. On reviewing the allegations for R20, R6 and R43 with the LSW the LSW verified the facility staff had failed to report incidents of suspected abuse or mistreatment to the administrator, DON and social services immediately and the LSW verified the vulnerable adult reports completed for R20, R6, and R43 were not made to the OHFC immediately. During an interview at 11:32 a.m. on 5/22/13 the director of nursing (DON) stated her expectation was all incidents of suspected abuse or mistreatment must be reported to the administrator, DON, and social services immediately and a report was to be completed immediately to OHFC. 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 that the vulnerable adult reports completed for R20, R6, and R43 were not made to the OHFC immediately. Review of the Reporting a Vulnerable Adult Incident an undated policy, instructed staff to: 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. " SUGGESTED METHOD FOR CORRECTION: The administrator, DON, social services or designee(s) could review and revise as necessary the policies and procedures regarding the internal process of reporting/investigating the process of abuse or maltreatment. The administrator, DON, social services or designee (s) could provide training for all appropriate staff on these policies and procedures. The	21995		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00754	A. BUILDING: _____ B. WING _____	05/22/2013

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21995	Continued From page 27 administrator, DON, social services or designee (s) could monitor to assure all reports of abuse are being reported and investigated. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21995		
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. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a	22000		

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22000	Continued From page 28 violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review, the 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.	22000		

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22000	Continued From page 29 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 METHOD FOR CORRECTION:	22000		

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22000	Continued From page 30 The Director of Nurses and/ or the Social Worker could provide education and training to all staff regarding reporting responsibilities and implementing the procedures of the Abuse Prevention Policy and Vulnerable adult(s) policy. TIME PERIOD FOR CORRECTION: Thirty (30) days.	22000		