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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9SQF F

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00407

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245395**
2.STATE VENDOR OR MEDICAID NO.
(L2) **146319500**

3. NAME AND ADDRESS OF FACILITY
(L3) **CROSSROADS CARE CENTER**
(L4) **965 MCMILLAN STREET**
(L5) **WORTHINGTON, MN** (L6) **56187**

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 **11/19/2013** (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)
12/31

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (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
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 01/03/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/25/2014 (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
01/01/1987
(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
12/11/2013
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5395

Post Certification Revisit (PCR) was completed November 19, 2013 and LSC PCR was completed on December 02, 2013. Refer to the 2567B.

Effective, November 5, 2013, the facility is certified for 50 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5395

March 25, 2014

Ms. Barbara Atchison, Administrator
Crossroads Care Center
965 McMillan Street
Worthington, Minnesota 56187

Dear Ms. Atchison:

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 November 5, 2013, the above facility is certified for:

50 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Ms. Barbara Atchison, Administrator
Crossroads Care Center
965 McMillan Street
Worthington, MN 56187

RE: Project Number S5240024

Dear Ms. Atchison:

On October 29, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard. 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 November 19, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 2, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 26, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 30, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 26, 2013, effective November 5, 2013 and therefore remedies outlined in our letter to you dated October 29, 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.

Sincerely,

Gary Nederhoff

Gary Nederhoff, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 507-206-2731 Fax: 507-206-2711

Enclosure

cc: Licensing and Certification File

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
245395	A. Building B. Wing	11/19/2013

Name of Facility	Street Address, City, State, Zip Code
CROSSROADS CARE CENTER	965 MCMILLAN STREET WORTHINGTON, MN 56187

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 F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 10/30/2013	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 10/30/2013	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 11/04/2013
ID Prefix F0315 Reg. # 483.25(d) LSC	Correction Completed 10/30/2013	ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 11/05/2013	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 10/30/2013
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 16022	Date: 1-3-14	Signature of Surveyor: 10160	Date: 1-3-14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 9/26/2013

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245395	01 - MAIN BUILDING 01	12/2/2013

Name of Facility	Street Address, City, State, Zip Code
CROSSROADS CARE CENTER	965 MCMILLAN STREET WORTHINGTON, MN 56187

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix ____ Reg. # NFPA 101 LSC K0018	Correction Completed 10/15/2013	ID Prefix ____ Reg. # NFPA 101 LSC K0052	Correction Completed 10/02/2013	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	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 16022	Date: 1/3/14	Signature of Surveyor: 22373	Date: 12/2/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 9/25/2013	____	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?		YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 9SQF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00407

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245395**

2.STATE VENDOR OR MEDICAID NO.
(L2) **146319500**

3. NAME AND ADDRESS OF FACILITY
(L3) **CROSSROADS CARE CENTER**
(L4) **965 MCMILLAN STREET**
(L5) **WORTHINGTON, MN** (L6) **56187**

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 **09/26/2013** (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)
12/31

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (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
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Robin Lewis, HFE NE II — 11/21/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 12/11/2013 (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
01/01/1987
(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
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

At the time of the standard survey completed September 26, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 1830 0003 8091 4486

October 29, 2013

Ms. Barbara Atchison, Administrator
Crossroads Care Center
965 McMillan Street
Worthington, Minnesota 56187

RE: Project Number S5395023

Dear Ms. Atchison:

On September 26, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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, Unit Supervisor
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 November 5, 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 November 5, 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 December 26, 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 March 26, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (612) 201-4124
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING _____ B. WING _____ NOV 18 2013	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSROADS CARE CENTER	965 MCMILLAN STREET WORTHINGTON, MN 56187

(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	**THE FOLLOWING PROVIDER RESPONSES ARE NEITHER AN ADMISSION OF NOR AGREEMENT WITH THE HEREIN ALLEGED DEFICIENCIES AND THEY SHOULD NOT BE CONSTRUED AS SUCH.**	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280 11/19/13 SPN	F 280 It is the policy of Crossroads Care Center to revise a resident's comprehensive care plan to reflect the resident's current assessments and needs in order to obtain the resident's highest obtainable level of independence. Resident R11's care plan was reviewed and updated to reflect current goals and approaches for managing incontinence. All licensed nurses are responsible for ensuring plan of care is current with resident needs. Licensed nurses are to review care plans per scheduled list each shift and update care plans as indicated as well as communicating changes to the Resident Care Coordinator. The Resident Care Coordinator is responsible for updating CNA assignment sheets with any changes.	

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

Barbara Atchison — Administrator — 11-14-13

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.

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	245395	A. BUILDING _____ B. WING _____	09/26/2013

NOV 18 2013
MN Dept of Health
Rochester

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F 280	Continued From page 1 by: Based on interview and document review, the facility failed to revise the comprehensive care plan to reflect the most current comprehensive bladder assessment for 1 of 2 residents (R11) reviewed for urinary incontinence. Findings include: R11 had a bladder assessment that included the check and change for incontinence every two hours but this had not been added to R11's comprehensive care plan for staff to follow when providing cares and services. R11 had been admitted on 1/6/06. R11sdiagnoses included but not limited to diabetes mellitus, senile dementia paranoid type, Alzheimer ' s disease. R11's quarterly Minimum Data Set (MDS) dated 7/24/13, identified R11 had severe cognitive impairment, was not on a toileting program, always incontinent of bladder and required extensive assistance with toileting needs. The CORP-One-Click (MDS) Report section H bladder and bowel date run 8/7/13, identified staff interview direct care certified nursing assistant (CNA), no comprehend should void on toilet, no longer identifies urges. Change to incontinence management check and change. Urinary assessment seven day look back dated 7/24/13, nurses summary identified toilet use extensive assist two person, urinary continence as always incontinent, wears incontinent brief, incontinence management every two hours toilet/check and change as needed. However, this intervention had not been added to R11 ' s comprehensive care plan. R11's care plan dated 8/7/13, read dependent on staff to manage all toileting needs, contributing factors cognitive impairment does not recognize	F 280	DON will conduct random audits of care plans and CNA assignment to oversee compliance. The survey findings and plan of correction will be reviewed with nursing staff on Oct 30, 2013, during mandatory in-service and results of audits will be reviewed at next quarterly QA committee meeting in January 2014. The QA committee will discuss and make recommendations if indicated for further interventions and ongoing monitoring to determine if interventions are effective and compliance is ongoing. Completion date: 10/30/13	10/30/13

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F 280	Continued From page 2 urges, extensive assist of two persons to seat and rise from toilet, incontinent bladder, assist to toilet every two to three hours during wake hours. Nursing assistant care sheet read extensive assist of one every two hours bladder incontinence; change Tena [incontinence product] per guidelines. During interview on 9/25/13, at 1:00 p.m., director of nursing (DON) verified R11's comprehensive care plan had not been updated to reflect the change in bladder incontinence treatment and services. Document review of the facility Goals and Objectives, Care Plans policy dated revised August 2006, read "Policy Statement Care plans shall incorporate goals and objectives that lead to the resident ' s highest obtainable level of independence."	F 280		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the comprehensive resident centered care plan was followed for personal hygiene for 2 of 3 residents (R50, R9) reviewed for activities of daily living and followed for 1 of 3 residents (R47) reviewed for urinary catheter use.	F 282	F 282 It is the facility's policy to provide services by qualified persons in accordance with each resident's written plan of care. It is expected that staff will provide assistance with ADLs per established plan of care for all residents. It is the policy of CRCC to encourage resident participation in ADL tasks within limits of disease processes and physical limitations to promote highest obtainable level of independence. CNAs are expected to provide setup for oral care twice daily and as needed and provide cues/assistance as needed for adequate completion of task as care planned. CNAs are expected to ensure completion of oral care in the morning and in the evening; before breakfast and again at HS. In addition it is the policy of this facility to complete shaving daily as needed before breakfast.	

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F 282	Continued From page 3 Findings include: R50's dentures were not cleaned according to their care planned needs. R50 was admitted on 5/14/13, with diagnoses including but not limited to dementia, gastric esophageal reflux disease and chronic renal failure. The current plan of care (POC) dated 5/31/13, indicated R50 had full dentures, upper and lower, staff assist of one to clean in morning and bedtime, apply adhesive in the morning and resident would assist to place in mouth. Staff was to set up equipment for resident to do oral cares in morning, and at bedtime, rinse mouth, use toothettes as needed to clean mouth. During interview on 9/24/13, at 10:05 a.m. R50 indicated staff assisted to brush dentures at least two to three times a week. During observation on 9/25/13, at 7:11 a.m. R50 was observed sitting on edge of the bed with wheeled walker in front of him transferring with one assist to the bathroom. Nursing assistant (NA)-C assisted resident with cares. NA-C picked up denture cup with lower denture in the cup and walked into the bathroom rinsed off lower denture and brought back to room. R50 took lower denture out of the cup and put the lower denture in mouth. NA-C was asked if R50 had upper teeth and NA-C verified R50 had upper teeth. NA-C had not set R50 up to clean upper denture as care planned. During interview on 9/25/13, at 7:38 a.m. R50 verified they had upper denture and had not been cleaned. R50 showed surveyor dentures and	F 282	Charge Nurses are responsible for assuring compliance at all times. Oral Care and Shaving procedure will be reviewed with all CNAs by 11/04/13. Charge nurses will monitor each shift and are responsible for providing education to staff in completion of cares per plan of care. Charge nurses on both shifts will conduct random audits weekly per DON direction to oversee compliance. Audits will be reviewed by DON and at the CNA QI meeting held in December and the next quarterly QA committee meeting in January 2014. The QA committee will discuss and make recommendations if indicated for further interventions and ongoing monitoring to determine if interventions are effective and compliance is ongoing. Resident #47's physician has been asked for an order to change to use of large urinary collection bag at all times to minimize opening closed drainage system and decrease risk for infection. Staff education was provided to licensed nurses during an in-service on 10/30/13 regarding compliance with plan of care and nurses' supervision responsibilities in ensuring that plan of care is followed. This incident to be included in the next quarterly QA Committee in January 2014. The QA committee will discuss and make recommendations if indicated for further interventions and ongoing monitoring. Completion date 10/30/13	

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F 282	Continued From page 4 visible food particles on the upper denture were observed. On 9/26/13, at 7:38 a.m. NA- D verified R50 had upper and lower dentures and were brushed in the morning when R50 gets up. During interview on 9/26/13, 9:17 a.m. the director of nursing (DON) indicated the facility tries to promote independence with set up and assist as needed. The DON verbalized the standard and expectation was staff performed oral cares in the morning and again in the evening and as needed according to care planned needs. The policy titled dentures, cleaning and storing dated 1/02, directed staff the purpose of cleaning dentures was to cleanse and "freshen" the resident's mouth. The general guidelines under the policy indicated denture care was to be provide before breakfast and at bedtime and to encourage resident to perform as much of the procedure as possible. R9 was observed to have unwanted facial hair and had been assessed to need total assistance of staff to maintain personal grooming which included the hair care per the comprehensive care plan. R9 was admitted on 8/12/08 with diagnoses that included but were not limited to dementia, diabetes and hypertension. Review of the care plan dated 8/26/08, revealed R9 required assist with hair care. During an observation on 9/24/13-13 at 9:25 a.m., R9 was observed to have short hairs around her	F 282		

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F 282	Continued From page 5	F 282		

chin and upper lip. On 9/25/13 at 8:31 a.m., R9 was observed to have short hairs around her chin and upper lip. Again on 9/26/13 at 9:46 a.m., R9 was observed to have short hairs around her chin and upper lip.

During interview on 9/25/13, at 1:23 p.m., nursing assistant (NA)-E indicated that facial hair removal was to be completed with morning cares on a daily basis. NA-A verified R9's morning cares were completed and verified shaving had not been completed for R9 today. NA-A verified resident had facial hair on her chin and upper lip.

During an interview on 9/25/13 at 1:39 p.m., the director of nursing (DON) stated she expected the nursing assistant to see if residents needed to be shaved when they were getting the residents ready for the day. If the residents needed to be shaved, I would expect the staff member to complete the task. The DON verified R9 had facial hair on her chin and upper lip. The DON verified the plan of care for assist with personal grooming to provide hair care included shaving facial hair, had not been followed for R9.
R47 care plan directed staff to put a urine collection leg bag on during the day however; it had not been done:

R47 was admitted on 7/10/13. R47's diagnoses included but not limited to uterine prolapse without vaginal wall prolapse, retention of urine. R47's admission Minimum Data Set (MDS) dated 7/16/13; identified R47 needed extensive assistance with toileting and had an indwelling Foley catheter.

R47's care plan dated 7/30/13, read urinary retention requires long term indwelling Foley

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F 282	Continued From page 6 catheter, dependent on staff to manage catheter needs, change Foley drainage bag to leg bag during wake hours, large drainage collection bag at bedtime per policy. Document review of physician orders dated 8/14/13, identified indwelling Foley catheter diagnosis retention of urine, change urinary drainage bag to a leg bag every morning and back to hanging bag at bedtime. Observations on 9/24/13 at 12:13 p.m. revealed R47 had an indwelling catheter with a catheter drainage bag covered by a cloth bag attached to R47's wheelchair. No leg bag was observed to be in place at this time. Observations on 9/25/13 at 7:09 a.m., revealed R47 sitting in wheelchair in dining room, catheter drainage bag covered by a cloth bag attached to R47's wheelchair. Again no leg bag was observed to be in place at this time. During interview on 9/26/13, at 7:49 a.m., DON verified R47's care plan had not been followed for catheter leg bag during wake hours. Document review of the facility Goals and Objectives, Care Plans policy dated revised August 2006, read "Policy Statement Care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence. 1. Care plan goals and objectives are defined as the desired outcome for a specific resident problem. 3. Care plan goals and objectives are derived from information contained in the resident's comprehensive assessment and: a. are resident orientated; d. Contain timetables to meet the resident's needs in accordance with	F 282		

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F 282	Continued From page 7 the comprehensive assessment."	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide personal hygiene needs per care plan for 2 of 3 residents (R50, R9) reviewed for activities of daily living. Findings include: R50's dentures were not cleaned according to the dental evaluation and care plan. R50 was admitted on 5/14/13, with diagnoses including but not limited to dementia, gastric esophageal reflux disease and chronic renal failure. The quarterly Minimum Data Set (MDS) dated 8/19/13, identified R50 had no cognitive impairment and required extensive assistance with one staff for personal hygiene. During review of oral dental status evaluation dated 5/17/13, identified R50 had upper and lower dentures, used adhesive and required staff assistance. R50's current plan of care (POC) dated 5/31/13, indicated R50 had full dentures, upper and lower, staff assist of one to clean in morning and	F 312	F 312 It is the facility's policy to provide necessary services to maintain grooming, nutrition and personal and oral hygiene for residents who are unable to carry out ADLs. Residents R50 and R9 were provided with oral care and shaving respectively on 9/26/13. Charge Nurses are responsible for assuring compliance at all times. Oral Care and Shaving procedures were reviewed with all CNAs by 11/04/13. Charge nurses will monitor CNAs on each shift and are responsible for providing education to staff in completion of cares per plan of care. Charge nurses on both shifts will conduct random audits weekly per DON direction to oversee compliance. Audits will be reviewed by DON and at the CNA QI meeting held in December and the next quarterly QA committee meeting in January 2014. The QA committee will discuss and make recommendations if indicated for further interventions and ongoing monitoring to determine if interventions are effective and compliance is ongoing. Completion date 11/04/13	

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F 312	Continued From page 8	F 312		

bedtime, apply adhesive in the morning and resident would assist to place in mouth. Staff was to set up equipment for resident to do oral cares in morning, and at bedtime, rinse mouth, use toothettes as needed to clean mouth.

During interview on 9/24/13, at 10:05 a.m. R50 indicated staff assisted to brush dentures at least two to three times a week.

During observation on 9/25/13, at 7:11 a.m. R50 was observed sitting on edge of the bed with wheeled walker in front of him transferring with one assist to the bathroom. Nursing assistant (NA)-C assisted resident with cares. NA-C picked up denture cup with lower denture in the cup and walked into the bathroom rinsed off lower denture and brought back to room. R50 took lower denture out of the cup and put the lower denture in mouth. NA-C was asked if R50 had upper teeth and NA-C verified R50 had upper teeth. NA-C had not set R50 up to clean upper denture as care planned.

During interview on 9/25/13, at 7:38 a.m. R50 verified had upper dentures and had not been cleaned. R50 showed surveyor dentures and they had visible food particles on the upper denture. R50 indicated he used denture adhesive and able to put on by self.

On 9/26/13, at 7:38 a.m. NA- D verified R50 had upper and lower dentures and were brushed in the morning when gets up.

During interview on 9/26/13, 9:17 a.m. the director of nursing (DON) indicated the facility tries to promote independence with set up and assist as needed. The DON verbalized the

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F 312	Continued From page 9 standard and expectation was staff performed oral cares in the morning and again in the evening and as needed according to care planned needs. The policy titled dentures, cleaning and storing dated 1/02, directed staff the purpose of cleaning dentures was to cleanse and freshen the resident's mouth. The general guidelines under the policy indicated denture care was to be provide before breakfast and at bedtime and to encourage resident to perform as much of the procedure as possible. R9 was observed to have facial hair and had been assessed to need total assistance of staff to maintain personal grooming which included the hair care per the comprehensive care plan. R9 was admitted on 8/12/08 with diagnoses that included but were not limited to dementia, diabetes and hypertension. Review of the quarterly Minimum Data Set (MDS) dated 7/8/13; revealed R9 required total dependence for staff for personal hygiene. Review of the care plan dated 8/26/08, revealed R9 required assist with hair care. During an observation on 9/24/13-13 at 9:25 a.m., R9 was observed to have short hairs around her chin and upper lip. On 9/25/13 at 8:31 a.m., R9 was observed to have short hairs around her chin and upper lip. Again on 9/26/13 at 9:46 a.m., R9 was observed to have short hairs around her chin and upper lip. During interview on 9/25/13, at 1:23 p.m., nursing assistant (NA)-E indicated that facial hair removal	F 312		

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F 312	Continued From page 10 was to be completed with morning cares on a daily basis. NA-A verified R9's morning cares had been completed and verified chin hair removal had not been completed for R9 today. NA-A verified R9 had facial hair on her chin and upper lip. During an interview on 9/25/13 at 1:39 p.m., the director of nursing (DON) stated she expected the nursing assistant to assist residents who needed to be shaved when they were getting the residents ready for the day. If the residents needed to be shaved, I would expect the staff member to complete the task. The DON verified R9 had facial hair on her chin and upper lip. The DON verified the plan of care for assist with personal grooming to provide hair care included shaving facial hair and this had not been done for R9.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide justification for	F 315	F 315 It is the policy of this facility to ensure assessments for incontinence and Foley catheter use are completed timely, interventions identified, implemented, monitored and revised as indicated in accordance with current standards of practice; and changes in condition are identified, evaluated, reported to primary care provider as indicated and addressed. It is the policy of CRCC to ensure any resident with urinary incontinence receives appropriate treatment and services to prevent UTI and to restore normal bladder function within limits of health conditions.	

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F 315	Continued From page 11 use of an indwelling catheter for 1 of 3 residents (R47) reviewed for urinary catheter usage and failed to ensure optimal bladder function for 1 of 2 residents (R11) reviewed for decline in urinary status. Findings include: R47 was admitted to the facility with a history of bladder problems which were verbally told to the staff by family. However, there is no medical justification as to why the indwelling Foley catheter is necessary. R47 was admitted on 7/10/13. R47's diagnoses included but not limited to uterine prolapse without vaginal wall prolapse, retention of urine. R47's admission Minimum Data Set (MDS) dated 7/16/13; identified R47 needed extensive assistance with toileting and had an indwelling catheter. R47's care plan dated 7/30/13, read urinary retention requires long term indwelling Foley catheter, history of severe urinary tract infection, bladder stretching, hypotonic and no longer able to let urine down, consult per urologist as needed, post void residual excessive, at risk for infection, dependent on staff to manage catheter needs. R47's admission urinary evaluation dated 7/17/13, identified indwelling catheter, reason for catheter use severe urinary tract infection with bladder expansion, large post void residual, uterine prolapse without vaginal wall prolapse and always continent. Summary toileting plan R47 continues with indwelling catheter for urinary retention due to bladder changes following severe urinary tract infection, family reports post void residual was great amount. All the information in regards to the urinary retention was provided by	F 315	Plan of care for R11 was updated 09/26/13 to match results of elimination assessment and CNA assignment sheets/CNAs instructed to report off to Charge Nurse when residents are last toileted before leaving floor for breaks and at end of shift as standard to ensure continuity of care as identified per written care plan. Review of protocol was completed with all CNAs by 11/04/13. Resident Care Coordinators and charge nurses are responsible for ensuring that plan of care is current and provides accurate information for CNA assignment sheets as reviewed in-service for licensed staff 10/30/13. DON is responsible for ensuring policy is being followed per weekly audit for period leading up to next quarterly QA Committee meeting in January 2014 at which time it will be determined if additional monitoring or change in interventions are indicated. It is the facility's policy that upon admission of any resident with indwelling Foley catheter, Resident Care Coordinator will be responsible for acquiring additional information if not present at admission from admitting facility/ care provider during initial MDS comprehensive assessment period; copies of urology consults, indications for catheter use, alternative interventions tried and outcome; any information pertinent to bladder function in addition to evaluating for treatable causes and attempting intermittent catheterization if condition allows. MD to evaluate and	

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	245395	A. BUILDING _____ B. WING _____	09/26/2013

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F 315	Continued From page 12 the family interview. Document review of physician orders dated 8/14/13, identified indwelling Foley catheter diagnosis retention of urine. Document review of physician progress note dated 8/14/13, lacked documentation of an evaluation of health status for justification for the use of the catheter. Observation on 9/24/13 at 12:13 p.m. revealed R47 had an indwelling catheter with a catheter bag covered by a cloth bag attached to R47's wheelchair. During interview on 9/25/13, at 8:50 a.m., director of nursing (DON) stated there was no doctor justification in R47's records for the use of an indwelling catheter. DON stated the information for use of indwelling catheter was provided by family upon admission. DON stated I can call the facility she was admitted from to see if there is documentation of a urology report. Document review of the facility Urinary Incontinence Clinical Protocol undated, read "Treatment/Management 5. When persistent or recurrent urinary retention is a problem, the staff and physician will seek treatable causes and try intermittent catheterization (if feasible) before placing an indwelling catheter. 8. The physician will identify situations where an indwelling urethral or suprapubic catheter are indicated, and will documents why other alternatives are not feasible." R11 had not been toileted for a period of three hours and thirty five minutes yet has an	F 315	document indications for ongoing catheter use and provide documentation as to why other alternatives are not indicated, to be completed upon first scheduled visit with resident. MD will provide cause identification for catheter use and assist as needed in identifying type of incontinence for residents with urinary incontinence. DON will audit bladder assessments and physician progress notes for residents with indwelling Foley catheter use for new admissions during interval leading up to Quarterly QA meeting for review 01/2014. Completion date 10/30/13	

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F 315	Continued From page 13 assessment that she should be toileted/checked/changed every two hours at a minimum. R11 had been admitted on 1/6/06. R11 ' s diagnoses included but not limited to diabetes mellitus, senile dementia paranoid type, Alzheimer's disease. R11's quarterly Minimum Data Set (MDS) dated 7/24/13, identified R11 had severe cognitive impairment, was not on a toileting program, always incontinent of bladder and required extensive assistance with toileting needs. On 8/7/13 an assessment identified that R11 had no comprehend should void on toilet, no longer identifies urges. Change to incontinence management check and change. Urinary assessment seven day look back dated 7/24/13, nurses summary identified toilet use extensive assist two person, urinary continence as always incontinent, wears incontinent brief, incontinence management every two hours toilet/check and change as needed, R11 is incontinent majority of time, when seated on toilet has no awareness of what should be doing, does not eliminate, and not a new decline. R11's care plan dated 8/7/13, read dependent on staff to manage all toileting needs, contributing factors cognitive impairment does not recognize urges, extensive assist of two persons to seat and rise from toilet, incontinent bladder, assist to toilet every two to three hours during wake hours. Nursing assistant care sheet read extensive assist of one every two hours bladder incontinence; change Tena an incontinence product per guidelines. This current care plan had not been updated to include check and change every two hours as an intervention to address bladder incontinence.	F 315		

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F 315	Continued From page 14 During constant observation on 9/24/13, from 12:09 p.m. until 3:44 p.m., a total of three hours and 35 minutes R11 had not been toileted or offered toilet. During interview on 9/24/13, at 3:51 p.m., nursing assistant-A stated R11 ' s toileting plan was every two hours change. Nursing assistant-A stated he did not know when the previous shift had last toileted R11, but the previous shift had stated R11 needs to go to the bathroom first. During interview on 9/24/13, at 3:55 p.m., licensed practical nurse (LPN)-B stated R11 ' s toileting plan was every two hours toilet, offer bathroom and check and change. During interview on 9/25/13, at 1:00 p.m., director of nursing (DON) verified documentation of Urinary assessment seven day look back dated 7/24/13 MDS Report section H bladder and bowel date run 8/7/13, nursing assistant care sheet and R11's care plan dated 8/7/13, had inconsistent documentation regarding R11's toileting schedule. The DON stated R11's toileting care plan interventions had not been updated to include the check and change every two hours and R11's toileting care plan should be check and change every two to three hours Document review of the Care Plan policy dated and revised August 2006, read "Policy Statement The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. Policy Interpretation and Implementation 2. The Nurse Supervisor uses the care plan to complete the	F 315		

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F 315	Continued From page 15 CNA's [certified nursing aides]daily/weekly work assignment sheets and/or flow sheets." Document review of the facility Urinary Incontinence Clinical Protocol undated, read "Assessment and Recognition 1. As part of the initial assessment, the physician will help identify individuals with impaired urinary continence; i.e., reduced ability to maintain urine in a socially appropriate manner. Cause Identification 1. The physician will help identify potentially treatable medical and psychiatric conditions related to an individual's continence status; for example, dementia and stroke. 3. The physician will help categorize incontinence as urge, stress, overflow, or functional."	F 315		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to store food in a sanitary manner in one walk-in cooler; failed to serve food in a sanitary manner; failed to ensure equipment used to cook food was maintained in clean condition and failed to ensure dish washer	F 371	F 371 It is the policy of Crossroads Care Center to store, prepare, distribute, and serve food under sanitary conditions The food in the walk in cooler was moved on 9-26-13 so that no food was placed where is might be contaminated. The walk-in cooler policy was reviewed with staff by dietary supervisor in training. The walk-in cooler was retro-fitted with a new, custom made drip pan to channel condensation into the floor drain. Work was completed on 10-30-13. The dietary supervisor in training will do random weekly audits of the walk-in cooler to assure that condensation is being channeled into the drain and that food is stored safely.	

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F 371	Continued From page 16 temperatures were within acceptable ranges for proper sanitation. This had the potential to affect 48 of 48 residents in the facility. Findings include: Walk in refrigerator had not been maintained to promote a sanitary ennvironment to prevent food borne illness: During the initial kitchen tour on 9/23/13, at 4:07 p.m., with dietary supervisor in training observation at this time revealed water pooled on the floor of the walk-in cooler. This was observed by the dietary supervisor in training at time. On 9/25/13, at 9:01 a.m., observation again revealed water on the floor of the walk-in cooler as it was two days ago. There were two white buckets sitting on the top shelf of a food rack and there had been food on the rack just below the buckets. One white bucket had been positioned under a fan built into the refrigerator. Dietary supervisor in training stated at this time that the water on the cooler floor was from water dripping by the fan. Dietary supervisor in training stated the white buckets were on the shelf to catch drips. Dietary supervisor stated maintenance had looked at the fan one month ago. Dietary supervisor in training verified potential for water to drip on the food stored on the racks below the buckets and fan. During interview on 9/25/13, at 11:43 a.m., maintenance (M)-A verified the fan in the refrigerator had been dripping water and he had looked at it. M-A stated the drain was not plugged causing the water to drip and a new evaporator pan was needed for the fan. During interview on 9/26/13, at 10:00 a.m.,	F 371	During food service, staff will change gloves if they become contaminated. The policy for food handling was reviewed with staff by dietary supervisor in training. The dietary supervisor in training will do random weekly audits on both shifts to insure that food is being handled safely. The oven was cleaned on 9-30-13. The policy for oven cleaning was reviewed with staff by dietary supervisor. The dietary supervisor in training will do random weekly audits to insure that cleaning has been completed according to policy. Dishes were done by hand in the three compartment sink until the dishwasher temperature reached 120 degrees or higher. On 10-2-13 dishwasher temperatures were at 122 degree and are being maintained at that temperature, monitored and recorded twice a day by dietary aides. Maintenance staff will also be doing random audits to ensure temperature is being maintained at 120-160 degrees. Dishwasher policy was reviewed with dietary staff by dietary supervisor in training. Dietary policies regarding low temp dishwasher, food handling, walk-in cooler and oven cleaning policies have been reviewed and revised. Dietary staff will read and sign policies by 11-5-2013. Results of audits will be reviewed at the quarterly Quality Assurance Committee meeting. Completion date: 11-5-2013	

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F 371	Continued From page 17 registered dietician consultant stated she would expect the fan in the walk-in cooler to be checked by maintenance to identify the cause of the dripping and fixed. Registered dietician consultant stated food should not be stored under where the fan is dripping. Document review of the facility Policy/Procedure walk-in cooler undated, read "It is the policy of Crossroads Care Center to ensure the proper sanitation and storage of the walk in cooler" this is in reference to food items being stored in a sanitary environment. Sanitary practices were not followed when serving food to residents during the meal: During meal service observation while in the kitchen on 9/25/13, at 11:55 a.m., cook-A was observed picking up hamburger buns with the same pair of gloves that had touched a handle of a food cooler, cardboard box containing chips and had pushed a button on a walkie-talkie that had been hanging on her uniform and had not changed gloves when they were soiled or washed hands before coming in direct contact with food items. During interview on 9/25/13, at 12:05 p.m., cook-A verified she had picked up hamburger buns with the same pair of soiled gloves she had touched a handle of a food cooler, cardboard box containing chips and button on a walkie-talkie radio. During interview on 9/25/13, at 12:08 p.m., dietary supervisor in training stated she would expect staff person to change gloves, wash hands and put on new gloves if contaminated during the	F 371		

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F 371	Continued From page 18 serving of food. During interview on 9/26/13, at 10:00 a.m., registered dietician consultant stated she would expect staff to change gloves when they touch dirty items during food service, so they do not touch food with dirty gloves. Document review of the facility Dietary/Food Handling undated, read "General Guidelines 17. i. Gloves will be worn when coming in contact with food that is going to be served to residents. j. Gloves will be changed when coming in contact with anything contaminated." Oven had not been maintained in a sanitary condition which is used for resident food preparation: During tour of the kitchen on 9/25/13, at 9:01 a.m., observation revealed the right oven of a stove had a thick layer of black build up inside the bottom of the oven, dietary supervisor in training verified at the time. Dietary supervisor in training stated the oven had last been cleaned on September fifteenth and the ovens were to be cleaned weekly. Document review of the kitchen cleaning schedule dated September 2013, identified the oven had last been cleaned on September 15, 2013. During interview on 9/26/13, at 10:00 a.m., registered dietician consultant stated she would expect the facility to clean the oven on a regular basis. Document review of the facility Procedure: Cleaning the oven undated, read "Frequency	F 371		

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F 371	Continued From page 19 Weekly on Sunday." Sanitation of dishes/pots pans/utensils, etc. was compromised due to the dishwasher cold temperature water not reaching the range of 120 degrees Fahrenheit: During observation on 9/25/13, at 9:20 a.m., dietary assistant-A had been washing a load of dishes. The surveyor observed the temperature of the wash cycle had reached 98 degrees Fahrenheit and asked the dietary assistant-A to verify the temperature of the wash cycle at the same time and dietary assistant-A stated the gauge read 98 degrees Fahrenheit. Dietary assistant-A then rewashed the load of dishes and verified at that time the gauge for the wash cycle temperature reached 105 degrees Fahrenheit. Dietary assistant-A then rewashed the load of dishes a third time and verified at the time the gauge read during the wash cycle temperature had reached 105 degrees Fahrenheit. Shortly after these low readings the maintenance person was called and on 9/25/13, at 11:43 a.m., maintenance- (M)-A joined the dietary manager and surveyor in the kitchen. M-A had run the dishwasher at this time and the wash cycle reached 100 degrees Fahrenheit during first the run and 115 degrees Fahrenheit during the second run. Maintenance-A verified the wash cycle had not reached 120 degrees Fahrenheit. During interview on 9/26/13, at 10:00 a.m., registered dietician consultant stated she expected until the dishwasher had been fixed the washing process of dishes had to be done by hand. Document review of facility Low Temperature	F 371		

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F 371	Continued From page 20 Dish machine Procedure undated, read "2. Recommendation Temperature range for PPM range: a. Temperature range: 120 - 160 degrees" this is the optimal temperature range to kill organisms that could cause food borne illness.	F 371	F 431 It is the policy of Crossroads Care Center to document destruction of controlled substances. When removing Fentanyl patches, nurses are to wear gloves, fold Fentanyl patch inward upon removal, medication side to medication side, and dispose of Fentanyl patch into sharps container. Documentation is to include drug name, strength, quantity disposed of, method of disposition and signature of 2 persons per current regulation guidelines (licensed nurses or licensed nurse/registered pharmacist). The policy/procedure for correct disposition of Fentanyl patches was reviewed with licensed nurses at an in-service on 10/30/13. The DON will audit for correct disposition and documentation of destroyed medication weekly x 8 weeks followed by random audits until next quarterly QA meeting in January 2014at which time results of audits will be reviewed and the QA Committee will determine if additional intervention is required. Correction date 10/30/13	
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431		

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F 431	Continued From page 21 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to document destruction of a controlled substance and this had the potential to affect 48 of 48 residents residing in the facility. Findings include: It was learned that the facility had not documented actual disposition of used fentanyl patches. Fentanyl patches are a schedule II controlled medication. During interview on 9/26/13, at 9:04 a.m., the director of nursing (DON) stated when used fentanyl patches are removed we fold the medication side to medication side and then dispose of the fentanyl patch into a sharps container located on the medication cart or into a sharps container located in the residents bathroom. On questioning about the log or documenting that it had been completed the DON stated there is no log of destruction for the used fentanyl patches. Document review of the facility Medication Destruction undated, read "III. Procedure: B. Medications that are controlled substances will be destroyed in the facility by a pharmacist and a registered nurse. C. Documentation of destruction will be completed and a record of this maintained. Documentation will include the drug name and strength, quantity destroyed, method of destruction, and the signatures of persons completing destruction."	F 431		

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			Crossroads Care Center objects to and disagrees with both the findings of non-compliance and the level of deficiencies cited. Submission of this Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statements of Deficiency were correctly cited, and is also not to be construed as an admission against interests of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of Deficiencies as a condition to participate in the Medicare and Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by Facility. Date Certain: 11-5-13	

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

F539502

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OMB NO. 0938-0391

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CROSSROADS CARE CENTER	**965 MCMILLAN STREET** **WORTHINGTON, MN 56187**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on September 25, 2013. At the time of this survey, Crossroads Care Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	POC ok TS 11-21-13 RECEIVED NOV 20 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 11-5-13

EXIT: 9-26-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Barbara Atchison	Administrator	11-14-13

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
	245395	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/25/2013**

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K 000	Continued From page 1 By eMail to: Barbara.Lundberg@state.mn.us, and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Crossroads Care Center was constructed as follows: The original building was constructed in 1953, is one-story in height, has a full basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1968 Addition is one-story in height, has a full basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The facility has smoke detection in the corridors and spaces open to the corridors, which are monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 48 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than	K 018		

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K 018	Continued From page 2 required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, corridor doors were not equipped with latching hardware, preventing the doors from positively latching into their frames. This deficient practice was not in accordance with NFPA 101 (2000) Chapter 19, Section 19.3.6.3. In a fire emergency, this deficient practice could adversely affect 50 of 50 residents. FINDINGS INCLUDE: On 09/25/2013 between 12:30 PM and 3:30 PM, observation revealed the corridor doors to the following rooms were not equipped with door latching hardware, and did not positively latch into their frames: A). Medical Room #1;	K 018	K 18 It is the facility's policy to ensure that doors meet the NFPA 101 Life Safety Code Standard The doors on the medication storage rooms that did not positively latch were modified on 10-15-13 by a local locksmith so as to positively latch. The Maintenance Supervisor will audit all doors in the facility, modify and/or adjust as necessary to ensure continued compliance. Completion date: 10-15-13	

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K 018	Continued From page 3 B). Medical Room #2. These findings were verified with the chief building engineer at the times of discovery.	K 018	K 52	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based upon a review of available documentation, the facility failed to maintain the building fire alarm system in accordance with NFPA 101 (00) Chapter 9, Section 9.6 and Chapter 19, Section 19.3.4.1. and NFPA 72 (1999 edition) Sections 7-3.2 and 7-5.2.2 and Table 7-3.1. In a fire emergency, this deficient practice could adversely affect 50 of 50 residents. FINDINGS INCLUDE: On 09/25/2013 at 1:45 PM, during a review of the facility's Fire Alarm Test Report dated 07/01/2013, approximately 56 alarm initiating devices were noted on the system, however, no documentation was provided identifying the locations, serial	K 052	It is the facility's policy that all inspections of fire alarm system are documented as per the current Life Safety Code. The form titled, Fire Alarm System Testing, (elements required from NFPA72-1999 edition, as referenced in the 2000 edition of the Life Safety Code, was faxed to the facility's vendor, ABC Alarm Systems, on 10/1/13 in order for the vendor to complete the form as per the most recent inspection. ABC Alarm System had completed the correct form during its most recent annual testing but had not provided a copy to the facility. ABC provided the completed form to the facility on 10-2-13and the form was placed in the Life Safety documentation manual. The Maintenance Supervisor will ensure that ABC provides the same form upon completion of each inspection/testing unless the requirements change, upon which the Maintenance Supervisor will provide the updated form in effect at the time of each inspection. The Maintenance Supervisor will be responsible for monitoring to ensure that all documentation is complete as required by the Life Safety Code in effect at the time of an inspection. Completion Date: 10-2-13	

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K 052	Continued From page 4 numbers, and outcomes for both visual and functional test results for each Alarm Initiating Device. As such, it could not be verified that visual and functional testing of each device on the fire alarm system had been properly conducted. This finding was confirmed with the chief building engineer.	K 052		