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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: BXGR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00470

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245251**

2.STATE VENDOR OR MEDICAID NO.
(L2) **861347800**

3. NAME AND ADDRESS OF FACILITY
(L3) **RIVERVIEW HOSPITAL & NURSING HOME**
(L4) **323 SOUTH MINNESOTA**
(L5) **CROOKSTON, MN** (L6) **56716**

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 **05/06/2014** (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 **24** (L18)

13.Total Certified Beds **24** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	24			
(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 :
Jana Bromenshenkel, HFE NEII — 05/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist 06/25/2014 (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
08/01/1982
(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
05/07/2014
(L33)

DETERMINATION APPROVAL

CCN: 24-5251

On May 6, 2014 a Post Certification Revisit was completed at this facility and verified correction of deficienceis issued pursant to the March 12, 2014 standard survey, effective May 6, 2014. Refer to the CMS 2567b for the results of this visit.

Effective May 6, 2014, the facility is certified for 24 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5251

June 25, 2014

Mr. John Mielke, Administrator
Riverview Hospital & Nursing Home
323 South Minnesota
Crookston, Minnesota 56716

Dear Mr. Mielke:

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 May 6, 2014 the above facility is certified for:

24 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 24 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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

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

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 21, 2014

Mr. John Mielke, Administrator
Riverview Hospital & Nursing Home
323 South Minnesota
Crookston, MN 56716

RE: Project Number S5251035

Dear Mr. Mielke:

On April 2, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 12, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On May 6, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 12, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 15, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 12, 2014, effective May 6, 2014 and therefore remedies outlined in our letter to you dated April 2, 2014, will not be imposed.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

5251r14epoc.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
245251	A. Building B. Wing	5/6/2014

Name of Facility	Street Address, City, State, Zip Code
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

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 **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **05/06/2014**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **05/06/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **05/06/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **05/06/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **05/06/2014**	ID Prefix **F0492** Reg. # **483.75(b)** LSC	Correction Completed **05/06/2014**
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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/LB	05/21/2014	32601	05/06/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 3/12/2014

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: BXGR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00470

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245251**

2.STATE VENDOR OR MEDICAID NO.
(L2) **861347800**

3. NAME AND ADDRESS OF FACILITY
(L3) **RIVERVIEW HOSPITAL & NURSING HOME**
(L4) **323 SOUTH MINNESOTA**
(L5) **CROOKSTON, MN** (L6) **56716**

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 **03/12/2014** (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 **24** (L18)

13.Total Certified Beds **24** (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
	24			
(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 :
Vienna Andresen, HFE NEII 04/14/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/05/2014 (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 **08/01/1982** (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

CCN: 24-5251

SURVEY

At the time of the March 12, 2014 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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 2, 2014

Mr. John Mielke, Administrator
Riverview Hospital & Nursing Home
323 South Minnesota
Crookston, Minnesota 56716

RE: Project Number S5251035

Dear Mr.. Mielke:

On March 12, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), 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;

Electronic 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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman Supervisor
Bemidji Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

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 April 21, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 12, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 12, 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 an ePoC 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
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	03/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

(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 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 ONSITE 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		
F 282 SS=D	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 record review, the facility failed to ensure the monitoring of food and fluid intake was implemented as directed by the individual plan of care in order to minimize ongoing weight loss for 1 of 3 residents (R9) in the sample reviewed for nutrition and determined to be nutritionally at risk. The findings include:	F 282	-While hospitalized 11/5/2013 MD discussed possible colonoscopy with R9's family due to frequent loose stools and decreased appetite. Family declined and decided that they did not want any aggressive dietary interventions. 2/25/2014 Dietician noted that family was aware of weight trends and does not want aggressive nutritional intervention. They would like facility to attempt to give Resident whatever he would like to eat and drink but not force him to eat. Staff	4/4/14

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

Electronically Signed | 04/10/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	03/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

(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 282	Continued From page 1 R9's current plan of care (POC) updated 11/2013, indicated R9 had a potential for alteration in nutrition secondary to diagnosis of Alzheimer's dementia with history of poor oral intake and weight less than his ideal body weight range, chronic kidney disease, bowel perforation with colostomy 8/08 and history of significant weight changes. The POC directed staff to monitor R9's food preferences as needed, monitor intake/ weight, adjust portion sizes as needed, provide 120 milliliters fluid choice three times a day and to provide verbal cues at meal times and verbal encouragement to stay on task and continue eating. On 3/11/14, at 7:38 a.m. R9 was observed seated at the dining table with two other residents. R9 was served a large glass of apple juice, a large glass of whole milk, two slices of toast cut in half with peanut butter and a large banana sliced into sections. R9 was observed to independently drink all of the milk and juice and was provided another full glass of each. R9 independently ate 1/2 a piece of peanut butter toast and half of the banana slices. -At 8:03 a.m. R9 was observed to push the plate away and drink another full glass of apple juice. -At 8:09 a.m. R9 was observed to independently wheel himself out of the dining room. Facility staff were not observed to encourage R9 to eat more of the food offered and had not offered R9 any other food items prior to R9 leaving the dining room. On 3/11/14, at 11:46 a.m. R9 was again observed seated at the dining room table. R9 sat at the table for a couple of minutes and was observed to	F 282	would monitor intake at meals and supply R9 with snacks that usually appeal to him such as ice cream or banana bread. R9 currently has 3 pages of dislikes of food items. Foods are not added to this list unless verbalized at time of admission by residents or families or until they have been trialed more than once with Resident indicating dislike of item. Included in R9's list are numerous nutritional supplements. These supplements have been attempted numerous times with continued dislike of them. Resident does not respond well to things added to his drinks and becomes very paranoid. This was tried in the past causing R9 to stop drinking altogether. 3/4/2014 Dietician and RCC discussed continued weight loss and decreased appetite. Plan to update MD and suggest increase in Remeron to stimulate appetite. Resident has used Magase in the past and R9 would not tolerate again at this point. RCC spoke with family 3/5/14 regarding weight loss. They continue to not want aggressive interventions or staff to cause R9 to become angry or distressed due to continued verbal prompting. Plan at that time to observe eating habits daily and try to get Resident whatever he would eat or drink. 3/11/2014 MD increased Remeron in attempt to stimulate appetite. He also ordered a GI evaluation. RCC and MD discussed hospice due to advancing dementia. Dietician started resource juice and carnation instant breakfast and meal monitors initiated. 3/12/2014 RCC discussed MD visit with family and plan of treatment. They continue to not want	

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F 282	Continued From page 2 independently wheel himself back to his own room. At 11:54 a.m. licensed practical nurse (LPN)-A stated if R9 was not immediately served when seated in the dining room R9 would leave the dining room and return to his private room. At 12:00 p.m. R9 was observed in bed, asleep. R9 was served the noon meal in his room which consisted of a large glass of milk, a large glass of apple juice, two slices peanut butter toast cut into halves, a large banana cut into slices, a cup of ice cream and orange fluff desert. R9 was not provided the posted meal items from the planned menu. The posted planned menu consisted of chicken rice casserole, seasoned carrots, bread, margarine, ambrosia, juice, milk and coffee. From 12:02 p.m. until 12:45 p.m. R9 was observed to be left alone to eat the meal independently, in his room. R9 was not encouraged to eat any of the food items served during this meal. At 12:02 p.m. Registered Nurse (RN)-A stated R9 was served food items that he liked in an attempted to increase his intake. RN-A stated R9's choice of food likes and dislikes varied every day and explained what R9 liked yesterday may not be what he liked today. An attempt was made to review R9's food intake monitoring, however, it was determined the facility was not monitoring R9's food intake as directed by the POC.	F 282	aggressive dietary interventions and would like staff to offer foods and drinks that R9 would like. MD was contacted and orders received to honor family wishes and GI evaluation was cancelled. End Stage Dementia diagnosis was received as well. R9 very seldom leaves room per personal preference. Meal times are R9's main time for social stimulation outside of room and he becomes easily annoyed with staff and paranoid of increased attention at this time or if increased pressure is placed to eat or drink. All staff is aware of this and visually monitor his intake and if it is noticed that he is eating something more of that food is offered without request from R9. When it is observed that R9 is not eating what is provided alternate is offered or brought to room if R9 leaves before this is done in dining room. Care plan has been updated to reflect this. -3/14/2014 Dietician reviewed weights and care plans of all Residents. No concerns identified. -Weight Trends Policy and Procedure developed. Policy contains interventions to be put into place when concern of weight loss is identified. Nutrition and Diet Modification policy and Nutritional Assessment and Care Plans policy reviewed and updated. Weekly at IDT meetings the Weight Variance Report will be reviewed for any resident who has had a significant weight change. -Resident weights will be monitored by DON to observe for weight loss trend. If observed DON will audit that interventions are implemented per Weight Trends	

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F 282	Continued From page 3 On 3/11/14 at 12:55 p.m. the director of nursing (DON) confirmed staff had not monitored R9's intake since January 2014. The DON stated the facility's system for food intake monitoring was that all resident food and fluid intake was monitored only during the 7 day Minimum Data Set assessment period. The DON stated food intake monitoring was not completed even if the resident was at nutritional risk. On 3/11/14, at 1:12 p.m. the registered dietician (RD) stated her expectation was that R9 was served the 3 posted, planned meals every day. The RD confirmed facility staff should have encouraged R9 to eat during the meals as directed by his POC and to offer R9 other food choices when it was noted R9 was not eating food items served on the planned menu. The RD confirmed R9's intake monitoring was not completed as directed by his POC.	F 282	Policy and Procedure, Nutrition and Diet Modification Policy and Procedure and Nutritional Assessment and Care Plans Policy and Procedure. Audits will be completed weekly for 3 months of consecutive compliance then decreased to monthly for 3 months of consecutive compliance. Audit findings will be discussed at IDT meetings as well as quarterly Quality Assurance meetings.	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced	F 325		4/4/14

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F 325	Continued From page 4 by: Based on observation, interview, and record review, the facility failed to ensure weight loss interventions were consistently developed and implemented for 1 of 3 (R9) residents in the sample reviewed for weight loss. The findings include: On 3/11/14, at 7:38 a.m. R9 was observed seated in a wheelchair, at the dining table with two other residents. R9 was served a large glass of apple juice, a large glass of whole milk, two slices of toast with peanut butter, cut in half and a large banana sliced into sections. R9 was observed to independently drink all of the milk and juice and was provided another full glass of each. R9 independently ate 1/2 a piece of peanut butter toast and half of the banana slices. -At 8:03 a.m. R9 was observed to push his the plate away and drink another full glass of apple juice. -At 8:09 a.m. R9 was observed to independently wheel himself out of the dining room. Facility staff were not observed to encourage R9 to eat more of the food offered nor offer R9 any other food items prior to R9 leaving the dinning room. Additionally, R9 was not offered the food items on the posted, planned menu which consisted of Malt-O-Meal, egg & ham bake, toast, jelly, peanut butter, juice, milk and Coffee. On 3/11/14, at 11:46 a.m. R9 was observed seated at the dining room table. R9 was observed to remain seated at the table for a couple of minutes and then independently wheeled himself	F 325	-While hospitalized 11/5/2013 MD discussed possible colonoscopy with R9's family due to frequent loose stools and decreased appetite. Family declined and decided that they did not want any aggressive dietary interventions. 2/25/2014 Dietician noted that family was aware of weight trends and does not want aggressive nutritional intervention. They would like facility to attempt to give Resident whatever he would like to eat and drink but not force him to eat. Staff would monitor intake at meals and supply R9 with snacks that usually appeal to him such as ice cream or banana bread. R9 currently has 3 pages of dislikes of food items. Foods are not added to this list unless verbalized at time of admission by residents or families or until they have been trialed more than once with Resident indicating dislike of item. Included in R9's list are numerous nutritional supplements. These supplements have been attempted numerous times with continued dislike of them. Resident does not respond well to things added to his drinks and becomes very paranoid. This was tried in the past causing R9 to stop drinking altogether. 3/4/2014 Dietician and RCC discussed continued weight loss and decreased appetite. Plan to update MD and suggest increase in Remeron to stimulate appetite. Resident has used Magase in the past and R9 would not tolerate again at this point. RCC spoke with family 3/5/14 regarding weight loss. They continue to not want aggressive interventions or staff to cause R9 to become angry or	

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F 325	Continued From page 5 out of the dining room and back to his room. On 3/11/14, at 11:54 a.m. licensed practical nurse (LPN)-A stated if R9 was not immediately served when seated in the dining room he would leave the dinning room and return to his own room. On 3/11/14, at 12:00 noon R9 was observed asleep in bed. Shortly- thereafter R9 was served the noon meal in his room which consisted of a large glass of milk, a large glass of apple juice, two slices peanut butter toast cut into halves, a large banana cut into slices, a cup of ice cream and orange fluff dessert. R9 was not provided the posted, planned menu food items which consisted of chicken rice casserole, seasoned carrots, bread, margarine, ambrosia, juice, milk and coffee. From 12:02 p.m. until 12:45 p.m. R9 was observed to be left alone in his room to eat the meal and was not encouraged to eat any of the food items. At 12:45 p.m. R9's meal tray was removed from his room. R9 had consumed one half slice of peanut butter toast. On 3/11/14, at 12:02 p.m. registered nurse (RN)-A stated R9 was served food items that he liked in an attempted to increase his intake. RN-A also stated R9's choice of food likes and dislikes varied every day and explained what R9 liked yesterday he may not like today. At 12:45 p.m. when asked if R9 received peanut butter toast and banana's for every meal, nursing assistant (NA)-C stated R9 had received those food items for every meal because R9 was	F 325	distressed due to continued verbal prompting. Plan at that time to observe eating habits daily and try to get Resident whatever he would eat or drink. 3/11/2014 MD increased Remeron in attempt to stimulate appetite. He also ordered a GI evaluation. RCC and MD discussed hospice due to advancing dementia. Dietician started resource juice and carnation instant breakfast and meal monitors initiated. 3/12/2014 RCC discussed MD visit with family and plan of treatment. They continue to not want aggressive dietary interventions and would like staff to offer foods and drinks that R9 would like. MD was contacted and orders received to honor family wishes and GI evaluation was cancelled. End Stage Dementia diagnosis was received as well. R9 very seldom leaves room per personal preference. Meal times are R9's main time for social stimulation outside of room and he becomes easily annoyed with staff and paranoid of increased attention at this time or if increased pressure is placed to eat or drink. All staff is aware of this and visually monitor his intake and if it is noticed that he is eating something more of that food is offered without request from R9. When it is observed that R9 is not eating what is provided alternate is offered or brought to room if R9 leaves before this is done in dining room. Care plan has been updated to reflect this. -3/14/2014 Dietician reviewed weights and care plans of all Residents. No concerns identified. -Weight Trends Policy and Procedure	

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F 325	Continued From page 6 refusing to eat everything else offered to him and staff found that R9 would eat the peanut butter toast and banana's so then staff started serving R9 peanut butter toast and bananas for every meal in order to increase R9's intake. R9's plan of care (POC) updated on 11/2013, indicated R9 had a potential for alteration in nutrition secondary to diagnosis of Alzheimer's dementia with history of poor oral intake and weight less then his ideal body weight range, chronic kidney disease, bowel perforation with colostomy 8/08, history of significant weight changes, moved to memory care unit 6/24/09, weight stable (8/13), weight down 6.7% in one month (10/13), was hospitalized 11/13, for urinary tract infection, GI bleed and pneumonia. The POC directed staff to monitor R9's food preferences as needed, monitor intake/ weight and adjust portion sizes as needed, provide additional nutritional supplementation as needed to maintain weight goal and to monitor R9's weight weekly. The POC also directed staff to provide R9 a regular diet with small portions, 120 milliliters (ml) fluid choice three times a day, Ensure (Strawberry) Plus 120 ml twice a day with medications and provide R9 verbal cues and verbal encouragement to stay on task and continue eating during meals. The POC indicated Remeron was ordered by R9's physician to increase R9's appetite/intake. The POC went on to read R9 ate meals in the dining room, R9 was independent with eating following some assistance with meal setup (i.e.: applying condiments, opening cartons, pouring liquids, and cutting food) and directed staff to provide verbal encouragement to come to the dining room for meals and to continue eating. The POC indicated	F 325	developed. Policy contains interventions to be put into place when concern of weight loss is identified. Nutrition and Diet Modification policy and Nutritional Assessment and Care Plans policy reviewed and updated. Weekly at IDT meetings the Weight Variance Report will be reviewed for any resident who has had a significant weight change. -Resident weights will be monitored by DON to observe for weight loss trend. If observed DON will audit that interventions are implemented per Weight Trends Policy and Procedure, Nutrition and Diet Modification Policy and Procedure and Nutritional Assessment and Care Plans Policy and Procedure. Audits will be completed weekly for 3 months of consecutive compliance then decreased to monthly for 3 months of consecutive compliance. Audit findings will be discussed at IDT meetings as well as quarterly Quality Assurance meetings.	

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F 325	Continued From page 7 R9 received Ensure Plus 120 ml twice a day with medications and directed staff to encourage high calorie preferred food/fluids at meals/snacks (res likes ice cream and bananas). R9's weight record indicated the following: -3/10/14: R9 weighed 110 pounds. -2/10/14: R9 weighed 116 pounds which indicated R9 had a weight loss of 5.5% of body weight in one month from 2/10/14-3/10/14. R9's Nutritional Assessment dated 8/7/13, indicated R9 weighed 126 pounds with a loss of 16 pounds in the past 215 days). The assessment indicated R9's ideal weight range was 132-162 pounds with a usual body weight of 128-132 pounds. The analysis of the assessment read: "Res [resident] rec's [requires] a regular diet with small portions, resident rec's ensure plus nutritional supplements 120 ml BID [twice a day] to increase caloric consumption/day and to maintain wt, res also rec's 120 ml of fluid of choice TID [three times a day] to promote good hydration status and to prevent UTI's, no UTI's the past year...Res rec's remeron [an antidepressant medication sometimes used to stimulate appetite] daily secondary due to dx [diagnosis] of depression and to increase appetite/intake...to date res has no C/O [complaints of] nausea or GI complaints and no dark black stools noted...Res eats meals in the DR, [dinning room] res rec's assist with meal setup, rec's verbal encouragement to stay on task and complete meal, meals monitored during the assessment period with consumption of -60%, res cont's [continues] to refuse meals at times, current wt is static with last year's wt of 126#	F 325		

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F 325	Continued From page 8 suggesting caloric needs are being met with current intake. Res has upper denture, no lower teeth/denture present, res has no problems chewing/swallowing the regular texture w/ [with] thin liquids. Res is an 83 yo [year old] male, Ht [height] 5'7, current wt [weight] of 126# is static, BMI [basal metabolic index] 19.7 WNL [within normal limits] IBW [ideal body weight] range: 132#-162#, wt is within goal of maintaining weight: 125#-135#. Resident's nutritional status is quite stable, will con't with ensure plus supplements BID, con't to monitor wt weekly, monitor health status, monitor labs, and follow prn [as needed]. R9's quarterly nutrition assessment dated 1/14/14, completed by the registered dietician (RD) indicated R9 had extreme weakness, lethargy and had very poor oral intake with weight loss. The assessment indicated R9's weight was stable at 117 pounds and R9 had behaviors of refusing to eat, drink, and take medications. additionally. the assessment indicated R9's family was aware of R9's current nutritional deficiencies and requested no aggressive nutritional interventions (i.e. tube feeding). R9 ate meals in the dinning room or a room tray was provided with assist with meal set-up. The assessment indicated R9 liked small portions at meals, meal consumption was monitored during the MDS assessment period and R9 was identified to consume on average 30% of the meals. The assessment indicated R9 was offered high calorie snacks between meals and received nutritional supplements which included Ensure plus 120 ml twice a day. The assessment also indicated R9 "slightly under weight." The assessment indicated the plan for R9 was as follows: "Will monitor	F 325		

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F 325	Continued From page 9 weekly, con't [continue] with nutritional supplements/high calorie snacks between meals, encourage fluids/vitamin c juices secondary to prevent UTI's; for all dietetic problems/goals/approaches see nutrition care plan" The plan had not identified any new interventions to minimize the potential for further weight loss. R9's nutritional progress note dated 1/23/14, indicated the RD identified R9 continued to receive Ensure supplements and high calorie snacks, R9's weight was 117 pounds with a goal to increase weight to 125-135 pounds. No new weight loss interventions were identified nor developed to increase R9's weight. R9's nutritional progress note dated 2/25/14, indicated R9's weight had declined to 113 pounds with a weight loss of 3.5 pounds in the past week. The progress note identified R9 was refusing to eat foods that he once liked to eat and drank only sips of the Ensure plus nutritional supplement offered. The RD also indicated R9's family did not wish for aggressive nutritional interventions to be implemented and directed staff to continue to encourage R9's intake and to offer high calorie snacks between meals. The RD indicated she would continue to assess R9 weekly as R9 was at nutritional risk. The RD had not developed nor implemented any new interventions to minimize further weight loss. R9's nutritional progress note dated 3/4/14, indicated R9 weighed 110.5 pounds which represented a weight loss of 6 pounds in the past	F 325		

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F 325	Continued From page 10	F 325		

month. The progress note identified the RD consulted with the RN unit manager who identified R9 was refusing to eat food items he used to like. The note indicated a new intervention which included increasing R9's antidepressant medication (Remeron) in which R9's primary care physician would be contacted regarding this. Review R9's physician orders and physician progress notes revealed R9's primary physician had not increased the Remeron and also lacked a physician progress note which indicated R9's physician had been consulted regarding increasing the medication.

An attempt was made to review R9's food intake monitoring, however, it was determined the facility was not monitoring R9's food intake.

On 3/11/14, at 12:55 p.m. the director of nursing (DON) confirmed staff had not monitored R9's intake since January 2014. The DON stated the facility's system for food intake monitoring was that all resident food and fluid intake was monitored only during the MDS 7 day assessment period and further food intake monitoring was not completed even if a resident was at nutritional risk.

On 3/12/14, at 8:48 a.m. RN-B was observed to administer R9 medication with Ensure plus nutritional supplement drink. RN-B was observed to give R9 a few sips of the supplement along with the medications and place the remaining supplement on R9's bedside table and exit the room.

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F 325	Continued From page 11 Following the observation, RN-B verified she had given R9 the supplement in which R9 had only consumed sips of the drink. When asked if she routinely stayed with R9 to encourage he drank the entire supplement, RN-B stated "yes" if R9 accepted it but R9 did not want anymore of it. When asked how she knew R9 did not want any more of the supplement RN-B stated R9 held the drink away from his body which indicated he did not want anymore of it which was she left the remaining drink on R9's bedside stand. R9 was observed until 10:30 a.m. in which RN-B had not reapproached him to encourage he drink more of the supplement. R9's Medication Administration Record (MAR) from 2/1/14-3/11/14, revealed out of the 78 opportunity's for R9 to drink the Ensure Plus supplement, R9 had consumed less than 50% of the supplement 49 times and consumed over 50% of the supplement 29 times. On 3/11/14, at 1:12 p.m. the RD stated her expectation was for R9 to be served the three posted, planned meals every day. The RD stated she was not aware R9 was receiving toast with peanut butter and bananas instead of the planned menu. The RD confirmed R9 also received nutritional supplements which included Ensure plus 120 ml twice a day and high calorie snacks between meals. The RD also confirmed she knew R9 often did not drink the supplement. The RD verified she had not attempted to provide R9 with a high calorie breakfast supplement which could have been added to R9's milk during meals and had not recently attempted to provide a high	F 325		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 12 calorie juice supplement in order for R9 to increase caloric intake. The RD stated staff should have been encouraging R9 to eat during meals as directed by his POC. The RD also stated staff should have also offered R9 other food choices when it was noted he was not eating the planned menu food items. The RD confirmed intake monitoring had not been completed as directed by R9's POC.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. 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.	F 329		4/15/14

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	245251	A. BUILDING _____ B. WING _____	03/12/2014

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F 329	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a gradual dose reduction had occurred and justification / adequate indications for use were identified for the continued use of an antipsychotic and antidepressant medication for 1 of 5 (R5) residents in the sample reviewed for unnecessary medications. Findings include: R5's undated face sheet indicated R5's diagnoses included dementia with behavioral disturbances, depressive disorder and was on hospice until 12/19/13, for end stage dementia. The face sheet also indicated R5 lived in a locked memory facility. R5's significant change Minimum Data Set (MDS) dated 12/27/13, identified R5 had severe cognitive impairment and was rarely, never understood by others. The MDS also indicated R5 had no hallucination or delusional type behaviors. The MDS indicated R5 displayed physically abusive behaviors 1-3 days and wandered less than daily during the MDS assessment period which had no impact on R5, R5's cares nor other residents. R5's physician's orders dated 3/11/14, indicated R5 received Celexa (antidepressant) 10 milligrams (mg) daily which was started 10/24/11, for mood symptoms identified as refusing	F 329	-Diagnosis associated with Risperdal for R5 is nonorganic psychosis. 3/15/2014 R5's physician was updated regarding last reduction of Risperdal. 3/17/2014 orders were received to decrease dose to 0.125 mg QHS. Discussed R5's medications by IDT and plan put in place as to attempt to taper off of antipsychotic and attempt to reduce Celexa. -All residents' medication lists were reviewed by IDT and those receiving psychotropic medications without established plans for attempted reductions were identified. Plans put in place for those residents. Monthly Pharmacist Drug Regimen Review will be completed using new policy and procedure for all residents. -Plans put in place to attempt to reduce and in some cases discontinue medications for above identified residents. Due dates to contact physicians were established for these plans. Policy and procedure for Monthly Pharmacist Drug Regimen Review was updated to improve physician involvement and assure follow up measures are in place for identified and potential concerns. -Monthly Pharmacist Drug Regimen Review will be audited for completion and MD response monthly for 3 months of consecutive compliance. Findings will be discussed at quarterly QA meetings.	

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F 329	Continued From page 14 care/resistive to care, wandering in wheelchair, swearing and abusive to staff and other residents. The physician orders lacked indication a tapering of the medication dose occurred nor did it identify the physician's justification for the continued use of the medication since it had been started on 10/24/11. The orders also indicated R5 received Risperdal (antipsychotic) 0.25 mg daily which was started 5/14/13, when it was last successfully decreased for behaviors identified as refusing care/resistive to care, wandering in wheelchair, swearing and abusive to staff and other residents. R5's mood symptom monitoring from 1/1/14-3/10/14, (69 days), revealed R5 had displayed refusal/resistive to care 15 of the 69 days and swearing, abusive to staff or other residents on 20 of the 69 days reviewed. R5's plan of care (POC) dated 10/24/11, indicated R5 received antidepressant medication for depression. The POC directed staff to administer Celexa daily, to monitor the effectiveness of the medication, increase dosage gradually if needed, monitor R5's mood and response to the medication, assess/record effectiveness of the drug treatment and to monitor and report signs of sedation, hypotension, or anticholinergic symptoms. The POC also indicated R5 received antipsychotic medication for dementia with behavioral disturbances. The POC directed staff to monitor for drug effectiveness and adverse consequences and to quantitatively and objectively document R5's behavior. R5's physician's progress notes from	F 329		

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F 329	Continued From page 15 8/4/13-3/11/14, and revealed the following: -On 8/4/13, the physician progress note indicated mixed type dementia, overall R5 seemed to be doing reasonably well and plan to simply continue with his current dosage of Risperdal which seemed to be working for him. The note also indicated R5 was seen by this physician during nursing home rounds and since R5 he was last seen he has been doing quite well and staff report no sundowning or agitation. Additionally. the note indicated according to nursing staff R5 had not posed a management problem. -On 3/11/14, the physician's progress note indicated mixed type dementia and overall R5 seemed to be doing well at this point, plan to simply continue with his current dosage of Risperdal. The note further indicated R5 was seen by this physician on nursing home rounds and indicated R5 was doing quite well since the last physician visit with no sundowning or agitation. R5's physician progress notes lacked a physician comment on mood symptoms related to the use of Celexa and lacked identification of the behavioral symptoms which warranted the ongoing use of the antipsychotic medication and had not identified at what point the medication would be discontinued. R5's monthly pharmacist drug regimen review dated 12/29/13, indicated the pharmacist identified a drug irregularity for the use of both the Celexa 10 mg and Risperdal 0.25 mg daily and reported the findings to the director of nursing	F 329		

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F 329	Continued From page 16 (DON) and R5's physician. R5's PHARMACIST'S REPORT OF PHARMACEUTICAL SERVICES FOR THE RIVERVIEW NURSING HOME FOR December 2013, read: "Needs updates for usage of Risperdal and Celexa." The report submitted to the DON and physician had not specified what the "updates" should include. In addition, R5's PHARMACIST'S REPORT OF PHARMACEUTICAL SERVICES FOR THE RIVERVIEW NURSING HOME FOR January and February 2014, had not identified any further drug irregularities for R5 even though there had been no response from the physician for "Needs updates for usage of Risperdal and Celexa." On 3/12/14, at 9:46 a.m. the facility's consulting pharmacist verified in December 2013, the primary physician for R5 had been notified that updates for usage of Risperdal and Celexa were required. When questioned about what "updates" meant the pharmacist stated that either a dose reduction or justification of use was needed to be addressed by the physician. The pharmacist stated he sends the physician one notice about needing a "update" then waits for a response. The consultant pharmacist stated if the request for an update was not responded to by a physician by the next monthly drug regimen review he did not send the physician another notice to address the drug irregularity because he did not want to bother the physicians. On 3/12/14, at 9:50 a.m. registered nurse (RN)-A confirmed a tapering of the antidepressant medication had not been attempted since it was started on 10/24/11. RN-A also confirmed R5 lacked justification for the continued use of the	F 329		

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F 329	Continued From page 17 medication. RN-A stated R5 did not display psychotic type behavior including visual or auditory hallucinations or delusions. RN-A stated R5 displayed refusing/resistive to care, wandering in wheelchair, swearing and abusive to staff and other residents. RN-A confirmed R5 had a successful reduction of the antipsychotic medication on 5/14/13, going from Risperdal 0.25 mg twice a day to Risperdal 0.25 mg every day and verified a further reduction of the medication had not been attempted nor was there a physician justification for the ongoing use of the medication found in R5's medical record/physician progress notes. On 3/12/14, at 10:10 a.m. the DON confirmed she received a copy of the pharmacist drug regimen review report each month for her review. The DON confirmed the facility did not have a system in place to ensure that each pharmacist recommendation related to identified drug irregularities was followed up on.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		4/15/14

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F 428	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility consultant pharmacist failed to ensure a gradual dose reduction had occurred and justification / adequate indications for use were identified for the continued use of an antipsychotic and antidepressant medication for 1 of 5 (R5) residents in the sample reviewed for unnecessary medications. The findings include: R5's undated face sheet indicated R5's diagnoses included dementia with behavioral disturbances, depressive disorder and was on hospice until 12/19/13, for end stage dementia. The face sheet also indicated R5 lived in a locked memory facility. R5's significant change MDS dated 12/27/13, identified R5 had severe cognitive impairment and was rarely, never understood by others. The MDS also indicated R5 had no hallucination or delusional type behaviors. The MDS indicated R5 displayed physically abusive behaviors 1-3 days and wandered less than daily during the MDS assessment period which had no impact on R5, R5's cares nor other residents. R5's Physician's orders dated 3/11/14, indicated R5 received Celexa (antidepressant) 10 milligrams (mg) daily which was started 10/24/11, for mood symptoms identified as refusing care/resistive to care, wandering in wheelchair,	F 428	-Diagnosis associated with Risperdal for R5 is nonorganic psychosis. 3/15/2014 R5's physician was updated regarding last reduction of Risperdal. 3/17/2014 orders were received to decrease dose to 0.125 mg QHS. Discussed R5's medications by IDT and plan put in place as to attempt to taper off of antipsychotic and attempt to reduce Celexa. -All residents' medication lists were reviewed by IDT and those receiving psychotropic medications without established plans for attempted reductions were identified. Plans put in place for those residents. Monthly Pharmacist Drug Regimen Review will be completed using new policy and procedure for all residents. -Plans put in place to attempt to reduce and in some cases discontinue medications for above identified residents. Due dates to contact physicians were established for these plans. Policy and procedure for Monthly Pharmacist Drug Regimen Review was updated to improve physician involvement and assure follow up measures are in place for identified and potential concerns. -Monthly Pharmacist Drug Regimen Review will be audited for completion and MD response monthly for 3 months of consecutive compliance. Findings will be discussed at quarterly QA meetings.	

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F 428	Continued From page 19 swearing and abusive to staff and other residents. The physician orders lacked indication a tapering of the medication dose occurred nor did it identify the physician's justification for the continued use of the medication since it had been started on 10/24/11. The orders also indicated R5 received Risperdal (antipsychotic) 0.25 mg daily which was started 5/14/13, when it was last successfully decreased for behaviors identified as refusing care/resistive to care, wandering in wheelchair, swearing and abusive to staff and other residents. R5's mood symptom monitoring from 1/1/14-3/10/14 (69 days), revealed R5 displayed refusal of care/resistive to care on 15 of 69 days reviewed and swearing, abusive to staff and other residents on 20 of the 69 days reviewed. R5's physician's progress notes from 8/4/13-3/11/14, and revealed the following: -On 8/4/13, the physician progress note indicated mixed type dementia, overall R5 seemed to be doing reasonably well and plan to simply continue with his current dosage of Risperdal which seemed to be working for him. The note also indicated R5 was seen by this physician during nursing home rounds and since R5 he was last seen he has been doing quite well and staff report no sundowning or agitation. Additionally. the note indicated according to nursing staff R5 had not posed a management problem. -On 3/11/14, the physician's progress note indicated mixed type dementia and overall R5 seemed to be doing well at this point, plan to simply continue with his current dosage of	F 428		

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F 428	Continued From page 20 Risperdal. The note further indicated R5 was seen by this physician on nursing home rounds and indicated R5 was doing quite well since the last physician visit with no sundowning or agitation. R5's physician progress notes lacked a physician comment on mood symptoms related to the use of Celexa and lacked identification of the behavioral symptoms which warranted the ongoing use of the antipsychotic medication and had not identified at what point the medication would be discontinued. R5's monthly pharmacist drug regimen review dated 12/29/13, indicated the pharmacist identified a drug irregularity for the use of both the Celexa 10 mg and Risperdal 0.25 mg daily and reported the findings to the director of nursing (DON) and R5's physician. R5's PHARMACIST'S REPORT OF PHARMACEUTICAL SERVICES FOR THE RIVERVIEW NURSING HOME FOR December 2013, read: "Needs updates for usage of Risperdal and Celexa." The report submitted to the DON and physician had not specified what the "updates" should include. In addition, R5's PHARMACIST'S REPORT OF PHARMACEUTICAL SERVICES FOR THE RIVERVIEW NURSING HOME FOR January and February 2014, had not identified any further drug irregularities for R5 even though there had been no response from the physician for "Needs updates for usage of Risperdal and Celexa." On 3/12/14, at 9:46 a.m. the facility's consulting pharmacist verified in December 2013, the	F 428		

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F 428	Continued From page 21 primary physician for R5 had been notified that updates for usage of Risperdal and Celexa were required. When questioned about what "updates" meant the pharmacist stated that either a dose reduction or justification of use was needed to be addressed by the physician. The pharmacist stated he sends the physician one notice about needing a "update" then waits for a response. The consultant pharmacist stated if the request for an update was not responded to by a physician by the next monthly drug regimen review he did not send the physician another notice to address the drug irregularity because he did not want to bother the physicians. On 3/12/14, at 9:50 a.m. registered nurse (RN)-A confirmed a tapering of the antidepressant medication had not been attempted since it was started on 10/24/11. RN-A also confirmed R5 lacked justification for the continued use of the medication. RN-A stated R5 did not display psychotic type behavior including visual or auditory hallucinations or delusions. RN-A stated R5 displayed refusing/resistive to care, wandering in wheelchair, swearing and abusive to staff and other residents. RN-A confirmed R5 had a successful reduction of the antipsychotic medication on 5/14/13, going from Risperdal 0.25 mg twice a day to Risperdal 0.25 mg every day and verified a further reduction of the medication had not been attempted nor was there a physician justification for the ongoing use of the medication found in R5's medical record/physician progress notes. On 3/12/14, at 9:50 a.m. registered nurse (RN)-A confirmed a tapering of the antidepressant	F 428		

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F 428	Continued From page 22 medication had not been attempted since it was started on 10/24/11. RN-A also confirmed R5 lacked justification for the continued use of the medication. RN-A stated R5 did not display psychotic type behavior including visual or auditory hallucinations or delusions. RN-A stated R5 displayed refusing/resistive to care, wandering in wheelchair, swearing and abusive to staff and other residents. RN-A confirmed R5 had a successful reduction of the antipsychotic medication on 5/14/13, going from Risperdal 0.25 mg twice a day to Risperdal 0.25 mg every day and verified a further reduction of the medication had not been attempted nor was there a physician justification for the ongoing use of the medication found in R5's medical record/physician progress notes. On 3/12/14, at 10:10 a.m. the director of nursing (DON) confirmed she received a copy of the pharmacist drug regimen review report each month for her review. The DON confirmed the facility did not have a system in place to ensure that each pharmacist recommendation related to identified drug irregularities was followed up on.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441		4/1/14

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F 441	Continued From page 23 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility staff failed to wear appropriate personal protective equipment during the provision of care for 1 of 1 resident (R19) observed who was on isolation precautions. Findings included:	F 441	-3/11/2014 DON was notified of occurrence of improper contact isolation precautions for R19. Education was provided immediately to all staff working. Written education provided in communication book for all staff to review and nurses reviewed isolation precautions with CNA's during report. -No other Residents identified for having	

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F 441	Continued From page 24 R19's diagnoses as indicated on R19's Diagnoses Report - Clinical included Methicillin-resistant Staphylococcus aureus (MRSA) (antibiotic resistant infection). R19's plan of care (POC) dated 2/25/13, indicated R19 was placed in contact isolation. The POC directed staff to wear a gown or apron when possibility of contamination of clothes with blood or body fluids was anticipated. The untitled nursing assistant POC indicated R19 had a diagnosis of MRSA. On 3/10/14, at 3:43 p.m. nursing assistant (NA)-B was observed to enter R19's room. NA-B washed her hands and donned a pair of gloves. NA-B proceeded to reposition R19 and change R19's incontinent brief. At 3:45 p.m. NA-A entered R19's room and was observed to assist NA-B with R19's cares. NA-A stated she had washed her hands prior to entering the room and donned a pair of gloves. NA-A and NA-B continued with changing R19's brief and followed appropriate handwashing technique throughout the personal care. However, neither NA-A nor NA-B donned a protective gown during the changing of R19's incontinent brief. On 3/10/14, at 3:55 p.m. NA-A stated she should have worn a gown when changing R19's brief. On 3/10/14, at 4:03 p.m. NA-B stated she should have worn a gown when changing R19's brief. The facility's Multidrug Resistant Microorganisms (MDRO) policy reviewed 4/13, directed staff to wear a disposable gown during substantial	F 441	potential to be affected. -Education provided at staff meeting that all staff attended by RiverView Health Infection Control Nurse. -Weekly audit will be performed by DON to assure proper isolation precautions are being followed. Audits will be completed weekly for 3 months of consecutive compliance then decreased to monthly for 3 months of consecutive compliance. Audit findings will be discussed at IDT meetings as well as quarterly Quality Assurance meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	03/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

(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 441	Continued From page 25 contact with the patient. The facility's Guidelines for the Prevention and Control of Infectious Diseases [undated] directed staff to wear a gown when entering a patient's room that had been placed on contact precautions. On 3/11/14, at 1:25 p.m. director of nursing (DON) confirmed the facility's policy and stated her expectation was for staff to gown and glove when changing R19's brief.	F 441		
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure Medicare A beneficiaries that had requested a demand bill had not been charged for services while the decision was pending for 2 of 2 (R24, R20) residents in the sample who had requested 3 demand bills. Findings include: R24 had been charged for services while decision was pending on a demand bill. On 3/11/14, at 1:00 p.m. the facility's Accounts	F 492	-The Account Representative discussed with R24 family when they came to pay the bill that until they had the determination of the Demand Bill that they did not have to pay on the bill. He wanted to pay the bill at that time regardless of determination. The conversation was not documented but notification was completed. Deficient practice of R20 occurred at the time of billing and Demand Bill determination was in favor of facility and bill was paid for correct amount.	3/14/14

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	245251	A. BUILDING _____ B. WING _____	03/12/2014

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F 492	Continued From page 26 Representative reviewed the liability notices with the surveyor and the following was identified: R24, a medicare A beneficiary, was admitted on 11/21/13. The last covered day of skilled services was 1/6/14. Notice that R24's skilled services would be ending was given on 1/3/14, and R24's financial power of attorney (POA) had requested a demand bill on 1/4/14. R24 was again admitted to skilled services on 1/15/14, and last covered day was 1/31/14. Notice for discontinuation of skilled services was provided on 1/29/14, and signed by the POA for R24 on 2/3/14, where it was identified that a demand bill was requested. Review of the billing statement for 1/14, and 2/14, revealed R24 was charged for services and the financial POA for R24 had paid the bill even though the decision related to the outcome of the demand bill was still pending. R20, a medicare A beneficiary, was admitted to skilled services on 11/27/13, with the last covered day of skilled services identified was 12/1/13. Notice for denial was given on 11/29/13. On 11/30/13, R20 requested a demand bill as identified on the CMS form 10155. Review of the billing statement for 12/13, revealed R20 was charged for services and the bill had been paid even though the decision related to the outcome of the demand bill was still pending. On 3/11/14, at 1:30 p.m. the facility's Accounts Representative confirmed both R24 and R20 had	F 492	-No other Residents identified for having potential to be affected. -3/12/2014 Medicare Denial and Demand Billing Process policy updated and proper billing practice for those asking for demand bill was discussed with Account Representative. -Random audits will be performed by DON to assure proper policy is being followed. Audits will be completed weekly for 3 months of consecutive compliance then decreased to monthly for 3 months of consecutive compliance. Audit findings will be discussed at IDT meetings as well as quarterly Quality Assurance meetings.	

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F 492	Continued From page 27 requested a demand bill. The representative verified both residents were billed for services even though the decision related to the outcome of the demand bill was still pending. The facility policy, Medicare Denial Process and Demand Bill Procedure, revised 3/12/14, indicated a monthly statement of personal charges would be sent to the resident or responsible party with notification that a Demand Bill was pending and that "Payment is not required until determination of the Demand Bill has been received by Medicare." The policy indicated payment in full would be required once the Demand Bill determination in favor of the facility had been received.	F 492		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**03/11/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	**323 SOUTH MINNESOTA CROOKSTON, MN 56716**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire marshal Division on March 11, 2014. At the time of this survey RiverView Nursing Home 01 Main Building was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. RiverView Nursing Home is a 1-story building without a basement. The building was constructed at 2 different times. The original building was constructed in 1974 and was determined to be of a Type II(000) construction. In 2003 the south wing addition was built with additions to and remodeling of the north wing. It was determined to be of a Type V (111) construction. The building is divided into 6 smoke zones with fire barriers of at least 30 minutes. The facility has a fire alarm system with smoke detection throughout the corridor system and in the common spaces. The fire alarm system is monitored for automatic fire department notification and is installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). Hazardous areas have automatic fire detection that is on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The fire alarm has automatic fire department notification. The sleeping rooms created in 2003 have single station smoke detectors installed in accordance with the Minnesota State Fire Code (2007 edition) that alarm at the nurse's station and on the corridor	K 000		

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

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

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	245251	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**03/11/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 side of the rooms. The building has an automatic sprinkler system installed in accordance with NFPA 13 Standard for Installation of Automatic Sprinkler Systems (1999 edition). The facility has a capacity of 24 beds and had a census of 22 at the time of the survey. The facility was surveyed as one building. The 1974 portion of the building is not currently being used for healthcare. The requirement at 42 CFR, Subpart 483.70(a) is MET as evidenced by:	K 000		