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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: C63S

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 09/24/2013 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **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: **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 :
Rebecca Haberle, HFE NE II 11/13/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 12/20/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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
Posted 1/2/2014 C63S12 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/27/2013
(L33)

DETERMINATION APPROVAL

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

CCN: 245251

At the time of the standard survey completed August 1, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required. The facility was given an opportunity to correct before remedies were imposed.

On September 25, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 24, 2013 the Minnesota Department of Public Safety completed a PCR and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on August 1, 2013 effective September 24, 2013, therefore the remedies outlined in our letter to you dated August 20, 2013, will not be imposed. See attached CMS-2567B form for the results of the September 25, 2013 and September 24, 2013 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5251 December 20, 2013

Ms. Carrie Michelski, Administrator
Riverview Hospital & Nursing Home
323 South Minnesota
Crookston, Minnesota 56716

Dear Ms. Michelski:

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 September 24, 2013 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.

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

November 13, 2013

Ms. Carrie Michelski, Administrator
Riverview Hospital & Nursing Home
323 South Minnesota
Crookston, Minnesota 56716

RE: Project Number S5251034

Dear Ms. Michelski:

On August 20, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 1, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 25, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 24, 2013 the Minnesota Department of Public Safety completed a PCR by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 1, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 12, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 1, 2013, effective September 24, 2013 and therefore remedies outlined in our letter to you dated August 20, 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,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
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
245251	A. Building B. Wing	9/24/2013

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 **F0159** Reg. # **483.10(c)(2)-(5)** LSC	Correction Completed **09/24/2013**	ID Prefix **F0170** Reg. # **483.10(i)(1)** LSC	Correction Completed **09/24/2013**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **08/29/2013**
ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **09/24/2013**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **09/24/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **09/24/2013**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **09/24/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **09/24/2013**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **09/24/2013**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **09/24/2013**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **09/24/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/KJ	11/13/2013	18618	09/24/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/1/2013			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00470	A. Building B. Wing	9/24/2013

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 State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20480** Reg. # **MN Rule 4658.0260 Subp.** LSC	Correction Completed **09/24/2013**	ID Prefix **20555** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **09/24/2013**	ID Prefix **20905** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **09/24/2013**
ID Prefix **20915** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **09/24/2013**	ID Prefix **21015** Reg. # **MN Rule 4658.0610 Subp.** LSC	Correction Completed **09/24/2013**	ID Prefix **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	Correction Completed **09/24/2013**
ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1** LSC	Correction Completed **09/24/2013**	ID Prefix **21805** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **08/29/2013**	ID Prefix **21830** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **09/24/2013**
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

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/KJ	11/13/2013	03006	09/24/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/1/2013

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

November 13, 2013

Ms. Carrie Michelski, Administrator
Riverview Hospital & Nursing Home
323 South Minnesota
Crookston, Minnesota 56716

Re: Enclosed Reinspection Results - Project Number S5251034

Dear Ms. Michelski:

On September 24, 2013 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 1, 2013, with orders received by you on August 23, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Please feel free to call me with any questions.

Sincerely,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)
cc: Licensing and Certification File

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00470	A. Building B. Wing	9/24/2013

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 State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **20480** Reg. # **MN Rule 4658.0260 Subp.** LSC	**09/24/2013**	ID Prefix **20555** Reg. # **MN Rule 4658.0405 Subp.** LSC	**09/24/2013**	ID Prefix **20905** Reg. # **MN Rule 4658.0525 Subp.** LSC	**09/24/2013**
ID Prefix **20915** Reg. # **MN Rule 4658.0525 Subp.** LSC	**09/24/2013**	ID Prefix **21015** Reg. # **MN Rule 4658.0610 Subp.** LSC	**09/24/2013**	ID Prefix **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	**09/24/2013**
ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1** LSC	**09/24/2013**	ID Prefix **21805** Reg. # **MN St. Statute 144.651 Sul** LSC	**08/29/2013**	ID Prefix **21830** Reg. # **MN St. Statute 144.651 Sul** LSC	**09/24/2013**
ID Prefix Reg. # LSC	Completed	ID Prefix Reg. # LSC	Completed	ID Prefix Reg. # LSC	Completed
ID Prefix Reg. # LSC	Completed	ID Prefix Reg. # LSC	Completed	ID Prefix Reg. # LSC	Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/kj	11/13/2013	18618	09/24/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/1/2013			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: C63S

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 **08/01/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **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):
CCN: 245251

At the time of the August 1,2013 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Rebecca Haberle, HFV NEII 09/13/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist Sr. 09/27/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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
09/27/2013
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5551

August 20, 2013

Ms. Carrie Michelski, Administrator
Riverview Hospital & Nursing Home
323 South Minnesota
Crookston, Minnesota 56716

RE: Project Number S5251034

Dear Ms. Michelski:

On August 1, 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:

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601

Telephone: (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 September 10, 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 September 10, 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 November 1, 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 February 1, 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:

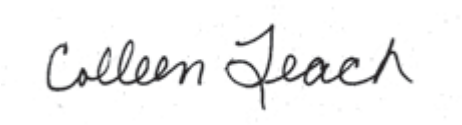
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 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
	245251	A. BUILDING _____ B. WING _____	08/01/2013

RECEIVED SEP 03 2013 Minnesota Department of Health Rezoldi

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'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	**F159** a. On 7/30/2013 the Patient Account Representative printed and provided a personal fund statement for Resident 9 and provided it to family member B. b. 8/1/2013 Copies of personal fund statements that had been sent to legal representatives of all other residents were reviewed and in order.	
F 159 SS=D	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal	F 159	c. 8/26/2013 a Resident Trust Fund policy was adopted and reviewed and understood by Administrator, DON, Social Service Designee and Patient Account Representative. d. DON will complete audits quarterly with Patient Account Representative to assure personal fund statements have been sent out for all residents until audits reach 100% for consecutive year. Findings of all audits will be discussed at IDT meetings as well as quarterly at Quality Assurance meetings. e. 8/26/2013	8/26/13 9/13/13 RDC DK 1c Addendum

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John Miller — TITLE: Administrator — (X6) DATE: 9/30/13

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
	245251	A. BUILDING _____ B. WING _____	08/01/2013

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 159	Continued From page 1 funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a quarterly personal fund statement for 1 of 1 resident (R9) in the sample reviewed for personal funds. Findings include: On 7/29/13, at 6:31 p.m. family member (FM)-B stated she had not recently received a personal fund statement for R9 and was unaware of what he had in this account. On 7/30/13, at 2:26 p.m. the patient account representative stated the personal funds account statements were mailed out quarterly, with the	F 159		

PRINTED: 08/20/2013
FORM APPROVED
OMB NO. 0938-0391

EPARTMENT OF HEALTH AND HUMAN SERVICES
ENTERS FOR MEDICARE & MEDICAID SERVICES

TEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	08/01/2013

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 159	Continued From page 2 most recent one having been sent in 4/13. The patient account representative provided a copy of the most recent statement sent to FM-B. Upon review, R9's Resident Trust Fund Statement was dated 1/2/13. The patient account representative confirmed this was the most recent quarterly personal funds account statement and that no statement had been sent to FM-B in 4/13.	F 159	F170 a. 7/31/2013 a policy was adopted outlining the procedure for obtaining and delivering resident mail for delivery 6 days a week, Monday through Saturday. On that date all activity staff was educated on the policy and procedure for mail delivery. b. By following the policy adopted 7/31/2013 all residents within the facility will have any mail received be delivered Monday through Saturday. c. 7/31/2013 a policy was adopted outlining the procedure for obtaining and delivering resident mail for delivery 6 days a week, Monday through Saturday. On that date all activity staff was educated on the policy and procedure for mail delivery. d. Activity Director will complete audits weekly to assure that mail is being delivered daily excluding Sunday. Will discuss audit findings weekly at IDT. When audits reach 100% compliance with mail delivery for 3 consecutive months will decrease audits to monthly and quarterly with continued compliance. Will discuss quarterly at Quality Assurance meetings. e. 8/5/2013	8/5/2013 8/5/13
F 170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to ensure mail was delivered to the residents on Saturdays. This practice had the potential to affect all 21 of 21 residents who resided in the facility. Findings include: On 7/30/13, at 11:32 a.m. social service designee (SSD)-A confirmed that since 11/12, the facility had not delivered mail to the residents on Saturdays.	F 170		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		

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 _____	08/01/2013

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 241	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to remove personal care equipment after use for 1 of 2 residents (R3) reviewed for dignity. Findings include: R3's diagnoses included dementia, Alzheimer's disease and osteoarthrosis. The quarterly Minimum Data Set (MDS) dated 7/16/13, indicated R3 was cognitively impaired and required extensive assist with bed mobility, transfers and ambulation. The Activities of Daily Living (ADL) Care Area Assessment (CAA) dated 5/3/13, indicated R3 required extensive assist of two for bed mobility, transfers, toileting, and ambulation. The CAA also indicated R3 required total assist with locomotion. The plan of care (POC) dated 7/3/13, indicated R3 was at risk for falls and directed staff to leave the transfer belt loosely on R3 at all times as R3 was quick to stand and attempt to move without assistance. During observations on 7/29/13, from 5:25 p.m. to 7:22 p.m. R3 was observed seated in her wheelchair in the dining room, eating her supper meal. R3 was noted to have a transfer belt on around her waist. On 7/30/13, at 8:00 a.m. R3 was observed seated in a wheelchair in the dining room, again wearing a transfer belt around her waist. At 9:09 a.m., R3 was observed to be transferred by two nursing	F 241	F241 a. Resident 3 had been wearing transfer belt continuously when up in chair per her plan of care and with consent from her daughter/POA. 8/2/2013 @ 0600 continuous use of transfer belt when Resident 3 was up was discontinued. Transfer belt was applied and used for all transfers and ambulation. Resident was very resistive to the application of the transfer belt and pushed body back into the chair upon each application. The repetitive application made Resident 3 very angry. Interventions were attempted to reduce this action by Resident 3 as bruising and self injury were a risk with this action. No interventions were successful and action was continued with each application of transfer belt. 8/3/2013 Resident 3 attempted to stand up from wheelchair x2. Staff was near and able to assist Resident 3 to sit down before attempted self transfer resulted in fall. Without transfer belt to use there was an increased possibility for injury to both Resident 3 and staff members. 8/4/2013 upon assessment by Resident Care Coordinator the increased anger and behaviors that repetitive application of transfer belt caused combined with the increased risk of injury presented when transfer belt was not able to be applied warranted the decision to again implement the use of continuously wearing transfer belt when up in chair. Daughter was consulted and agreed with assessment and plan of care was updated.	

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 _____	08/01/2013

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 241	Continued From page 4 assistants (NAs) to a recliner in the day room. The transfer belt was left around R3's waist. R3 was observed on 7/30/13, at 2:31 p.m. seated in a recliner in the day room with the foot rest elevated. The transfer belt was noted to be around her waist. At 3:22 p.m., R3 was observed to be transferred by NA-D and NA-F to a wheelchair. The belt was again left around her waist after the transfer. On 7/31/13, at 7:12 a.m. R3 was observed to be asleep in a day room recliner. The transfer belt was observed to be around her waist. At 7:51 a.m., R3 was observed to be transferred to a wheelchair by NA-B and licensed practical nurse (LPN)-A. The transfer belt was again left around her waist. From 8:05 a.m. to 9:22 a.m., R3 was observed seated in her wheelchair, in the dining room. At 9:27 a.m., NA-B and LPN-A transferred R3 to the toilet and then back to her wheel chair. Though cares and transferring were completed, the transfer belt remained around R3's waist. On 8/1/13, at 9:03 a.m. NA-C stated R3 did not stand and no longer required a transfer belt to be left on at all times. On 8/1/13, at 11:46 a.m. RN-B verified R3 had a history of self ambulation and falls therefore, the transfer belt was kept on R3 as a fall prevention intervention. However, RN-B confirmed R3 no longer walked independently and stated she no longer needed the transfer belt left on in between use. On 8/1/13, at 11:57 a.m. the DON verified that R3 was not ambulating or transferring without assist and did not require a transfer belt to be worn	F 241	b. There are 8 other residents who have it in the plan of care to wear transfer belt continuously when up in chair. Family has consented to this as well. Assessments were completed by the Resident Care Coordinator & DON 8/2/2013 and all 8 continue to warrant this as a fall reduction intervention. c. 8/22/2013 the Staff Use of Transfer Belts policy was reviewed by DON and found to be adequate and relevant. 8/23/2013 The Fall Prevention Program policy was updated to include the "use of continuous use of transfer belts when up in chair when the risk of falls from sudden attempts to stand are present" as an intervention that may be implemented in the fall prevention program. This policy also gives direction as to the systematic review of all interventions placed for fall prevention to assure individualized programs remain appropriate based on individual needs. 8/29/2013 these policies were reviewed by all staff. d. DON will audit weekly to assure that plan of care is being followed and Fall Prevention Programs are being reviewed per policy. Will discuss audit findings weekly at IDT. When audits reach 100% compliance for 3 consecutive months will decrease audits to monthly and quarterly with continued compliance. Will discuss quarterly at Quality Assurance meetings. e. 8/29/2013	8/29/13

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 _____	08/01/2013

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 241	Continued From page 5 outside of transfers.	F 241	F242	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based observation, interview and document review, the facility failed to ensure the morning routines of each resident, matched those of their previous lifestyle, for 1 of 3 residents (R8) whose morning cares were provided during the overnight shift. Findings include: R8's diagnoses included Alzheimer's disease, dementia with behavioral disturbances and depression. The quarterly Minimum Data Set (MDS) dated 7/7/13, indicated R8 had severe cognitive impairment and required total staff assistance for all activities of daily living. The plan of care revised 7/11/13, indicated R8 was non-verbal and directed staff to assist R8 with all activities of daily living. On 7/31/13, at 7:13 a.m. R8 was observed resting in her bed, fully dressed. At 8:00 a.m., nursing assistant (NA)-C and NA-E assisted R8 from her	F 242	a. 4/29/2013 & 7/18/2013 Nurse Leader Rounding was performed face to face with Resident 8's Family Member A. On both occasions Family Member A was asked "Does the staff honor Resident 8's preferences and previous life routines, such as when to get up and go to sleep or when to take a bath?" On both occasions she answered yes. 8/9/2013 the Social Service Designee spoke with Family Member A regarding getting Resident 8 dressed and left in bed at 5:30 AM. Family Member A stated that State Surveyors told her that Resident 8 was being gotten out of bed at that time. Family Member A indicated that it was ok with her if her mom was washed and dressed at 5:30 AM and then left in bed to sleep until breakfast. This has been Resident 8's routine for the last 5 years. Staff were informed of Family Member A's choice. b. 8/5/2013 all Nurse Leader Rounding logs were reviewed since beginning of implementation 2/28/2013 and all residents logs indicated that all families/responsible parties had answered yes to the question, "Does the staff honor Resident's name preferences and previous life routines, such as when to get up and go to sleep or when to take a bath?" c. Social Service Designee will update all residents Social Service Assessment and Social History to address and ensure accuracy of "Usual Daily Routine". Plan of care will then be updated	9/4/13

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 _____	08/01/2013

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 242	Continued From page 6 bed to the wheelchair via a full body mechanical lift. NA-C stated R8 had received morning cares by the night shift staff at approximately 4:30 a.m. On 7/31/13, at 8:26 a.m. licensed practical nurse (LPN)-A verified night shift staff typically completed R8's morning cares at approximately 5:00 a.m. each morning. On 7/31/13, at 10:00 a.m. family member (FM)-A stated R8 had worked out of the home previous to her stay at the facility and typically woke up between 6:00 a.m. and 7:00 a.m. FM-A stated she was aware R8 was receiving cares by the night staff because she understood it was necessary to help the day shift staff members with their morning duties. When asked if R8 routinely dressed before 5:30 a.m. FM-A stated at no time during R8's life had she routinely dressed before 6:00 a.m. FM-A added she could not recall the staff members asking permission or the family's input on providing care for R8 before 6:00 a.m. Review of the clinical record lacked a history of R8's previous life routine to include her customary morning routine. On 8/1/13, at 5:35 a.m. R8 was observed lying in bed, fully dressed. On 8/1/13, at 5:36 a.m. NA-F stated she had assisted R8 to dress around 5:00 a.m. NA-F also stated the night shift was assigned to assist three residents with morning cares prior to leaving at 7:00 a.m. and verified R8 was routinely provided morning cares at 5:00 a.m. On 8/1/13, at 7:10 a.m. registered nurse (RN)-B	F 242	to reflect resident chosen daily routine. RiverView Care Center Admission Assessment Policy/Procedure updated to indicate how to communicate previous daily routine to all staff to ensure preferences are honored. d. DON will audit weekly to assure that plan of care is being followed and preferences on daily routine are honored. Will discuss audit findings weekly at IDT. When audits reach 100% compliance for 3 consecutive months will decrease audits to monthly and quarterly with continued compliance. Will discuss quarterly at Quality Assurance meetings. e. 9/6/2013	9/6/13

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 _____	08/01/2013

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 242	Continued From page 7 confirmed R8 received morning cares daily by the night staff. RN-B stated she did not know how R8 had been chosen to receive early morning cares during the night shift "last rounds," which typically took place around 5:00 a.m. RN-B was unaware of R8's customary routine prior to residing at the facility and to her knowledge, R8's family members had not been asked about her previous life routine. On 8/1/13, at 7:25 a.m. NA-F (night shift NA) stated she had been instructed to assist three residents in the morning with cares before leaving the facility at 7:00 a.m. At 7:58 a.m. the social service designee (SSD) stated she had not been involved with choosing which residents received early morning cares. She confirmed getting dressed before 5:30 a.m. could be considered early and the residents customary routines should have been taken into consideration. The facility did not have policy regarding customary routines and the daily schedules of the residents.	F 242		
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	F 280	F280 a. 8/13/2013 PT saw Resident 3 to evaluate ambulation program. Due to resident's fluctuating abilities ambulation should be attempted 3-6 times a week with the distance as able. Resident 3's plan of care was update to reflect this evaluation. b. 8/2/2013 all rehab nursing programs were compared with plan of care to assure that plan of care was up to date. All other residents' plans of care were accurate.	8/29/13

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 _____	08/01/2013

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 280	Continued From page 8 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 by: Based on observation, interview and document review, the facility failed to revise the plan of care (POC) regarding ambulation services for 1 of 3 residents (R3) in the sample reviewed for ambulation. Findings include: R3's diagnoses included dementia, Alzheimer's disease and osteoarthrosis. The quarterly Minimum Data Set (MDS) dated 7/14/13, indicated R3 was cognitively impaired and required extensive assist of two staff for ambulation. The Activities of Daily Living Care Area Assessment dated 5/3/13, indicated R3 required two staff assist for ambulation. The POC updated 7/3/13, indicated R3 required extensive assist of two staff for ambulation. The POC ambulation goal indicated R3 would continue to ambulate 100-200 feet at a time with limited assistance and the use of a wheeled walker.	F 280	c. 8/2/2013 Care Plan, Comprehensive, Interim, Short Term policy was reviewed and found to be current regarding evaluating and revising the plan of care to reflect the resident's current status as required by law and regulation. 8/29/2013 staff meeting was held and education was given to all staff regarding communicating changes in resident's abilities so that the plan of care remains up-to-date. d. DON will audit weekly to assure that plan of care is being followed. Will discuss audit findings weekly at IDT. When audits reach 100% compliance for 3 consecutive months will decrease audits to monthly and quarterly with continued compliance. Will discuss quarterly at Quality Assurance meetings. e. 8/29/2013	8/29/13

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 _____	08/01/2013

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 280	Continued From page 9 A physical therapy evaluation screening dated 6/11/13, indicated R3 required maximum assistance of two staff to ambulate a few feet with a wheelchair and walker. The screening also directed staff to continue this ambulation program three times a week. The Seven Day Assessment tool dated 7/8/13-7/14/13, indicated R3 had not walked in the hall or in room, during the seven day assessment. On 7/30/13, from 8:00 a.m. until 9:09 a.m. R3 was observed in the dining room, seated in the wheelchair. At 9:09 a.m. R3 was observed to be transferred by two nursing assistants into a recliner in the day room. R3 was not observed to ambulate at this time. On 7/30/13, at 3:22 p.m. R3 was observed to be transferred by nursing assistant (NA)-D and NA-F from the recliner into her wheelchair. R3 was not ambulated at this time. On 7/31/13, at 7:51 a.m. R3 was observed to be transferred to a wheel chair by NA-B and licensed practical nurse (LPN)-A. On 7/31/13, at 9:27 a.m. NA-B and LPN-A was observed to transfer R3 to the toilet and then back to her wheel chair. R3 was not ambulated during this time. On 7/31/13, at 10:05 a.m. NA-E stated R3 no longer ambulated 100-200 feet. NA-E added, it had been several months since R3 was ambulated.	F 280		

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 _____	08/01/2013

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 280	Continued From page 10 On 7/31/13, at 12:45 p.m. NA-B stated R3 had not walked for at least 5 months. NA-B also stated she was not sure why R3 was not ambulating. However, NA-B stated sometimes R3 was resistive to cares but was "ok" if staff approached her later. On 8/1/13, at 9:03 a.m. the surveyor questioned NA-C regarding R3's ability to ambulate. At this time NA-C and NA-E was observed to assist R3 with ambulation to and from the rest room (25 feet each way) with the the use of a rolling wheeled walker. On 8/1/13, at 9:05 a.m. NA-E (rehab aide) stated nursing was responsible to ambulate R3. Additionally, NA-E stated she did not know if R3 was ambulating or not. On 8/1/13, at 11:46 a.m. registered nurse (RN)-B verified she was responsible for reviewing the range of motion (ROM) / ambulation documentation flow sheets and updating the POC's to reflect each residents ambulation / ROM abilities. RN-B verified R3's POC indicated R3 was to ambulate 100-200 feet each time. RN-B confirmed R3's POC was not updated to reflect her current ambulation abilities and should have been. On 8/1/13, at 11:57 a.m. the director of nursing (DON) verified R3's POC was not updated. The DON stated the POC's must be updated to reflect the current needs of each resident.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309	F309 a. 7/31/2013 OT completed a screen for wheelchair positioning for Resident 4. Resident	8/29/13

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 _____	08/01/2013

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 309	Continued From page 11 provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide proper wheelchair positioning for 1 of 1 resident (R4) reviewed for positioning. Findings include: R4's diagnoses included dementia and osteoarthritis, R4's annual Minimum Data Set (MDS) dated 6/30/13, indicated R4 had severe cognitive impairment and required extensive assist with positioning. R4's plan of care (POC) dated 12/22/11, indicated R4 required extensive staff assist for transfers and wheelchair mobility. The occupational therapy (OT) progress note dated 11/14/12, indicated R4 typically leaned to the left while seated. On 7/29/13, at 6:02 p.m. R4 was observed in the dining room seated in the wheelchair. R4's upper torso was observed leaning towards the left with her arm hung over the arm rest of the wheelchair and rested on the wheel of the chair. R4 was observed to attempt to reposition herself, but quickly reverted back to the left leaning position.	F 309	4's wheelchair is an 18" hemi-height wheelchair adjusted to low position. It has a posey reclining wheelchair back to accommodate her kyphotic posture. Resident 4 was noted to be leaning to the left with right hip elevated. When asked if she was comfortable Resident 4 stated that "yes" she was comfortable. When it was pointed out that her left side was leaning against the chair's arm rest she denied any discomfort from that. OT helped Resident 4 transfer into a straight-back chair with a firm seat where she initially showed improved posture with both elbows resting equally on the arm rests. Within 3-4 minutes Resident 4 resumed leaning to the left. OT trialed chair with and without an anti-sling mat beneath the Basic J cushion. Decided that it was slightly more comfortable with the anti-sling mat in place. 8/7/2013 OT was again contacted to screen Residents wheelchair positioning and anti-sling mat removed. Resident 4 immediately stated, "Oh, that's better." Due to continued leaning towards the left when in wheelchair. OT recommends that she should be assisted into a recliner or into bed for periods throughout the day. b. 7/31/2013 all other Residents were observed and appeared to be in proper position in their wheelchair. No residents verbalized discomfort or exhibited signs or symptoms of discomfort in their wheelchairs. c. 7/31/2013 Therapy (PT/OT/ST) Referral/Screening policy was adopted and reviewed and posted for all nursing staff to	

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 _____	08/01/2013

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 309	Continued From page 12 On 7/29/13, at 6:51 p.m. R4 was observed to remain seated in the wheelchair, in the common area watching television. R4's upper torso was observed to remain leaning towards the left in a twisted position. On 7/30/13, at 8:20 a.m. R4 was observed in the dining room, seated in her wheelchair. R4's upper torso was observed leaning towards the left . R4's upper body was observed positioned with her weight shifted toward the left and R4's left arm was observed to drop down over the arm of the wheelchair. On 7/30/13, at 8:37 a.m. R4 remained seated up in her wheelchair with her upper torso leaning towards the left. R4 stated she was not comfortable in her wheelchair. On 7/30/13, at 3:18 p.m. R4 was observed seated in her wheelchair in the dining room visiting with other residents. R4's upper body was observed twisted towards the left with her left arm hung over the left side of the wheelchair arm rest. On 7/31/13, at 7:14 a.m. R4 was observed in the common area seated in her wheelchair. R4's upper torso was leaning towards the left with her arm hung down over the arm rest. On 7/31/13, at 12:31 p.m. nursing assistant (NA) -A confirmed R4 was positioned in her wheelchair twisted and leaning towards the left. NA-A stated R4 frequently sat in this position when in her wheelchair. On 7/31/13, at 12:40 p.m. NA-B stated R4 always leaned to the left when seated in her wheelchair.	F 309	review. 8/29/2013 staff meeting was held and education on wheelchair positioning was provided as well as education on importance to report changes observed to nursing staff. All staff was in attendance. d. DON will complete audits weekly to assure all residents are positioned comfortably in their chairs. Will discuss audit findings weekly at IDT. When audits reach 100% compliance with proper wheelchair positioning for 3 consecutive months will decrease audits to monthly and quarterly with continued compliance. Will discuss quarterly at Quality Assurance meetings. e. 8/29/2013	8/29/13

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 _____	08/01/2013

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 309	Continued From page 13 On 7/31/13, at 2:02 p.m. the director of nursing (DON) verified R4 typically leaned towards the left when seated in her wheelchair. The DON stated R4 had been more comfortable in the upright position, therefore, preferred to sit in the wheelchair for the majority of the day. The DON verified the OT evaluation for wheelchair positioning was completed on 11/14/12. In addition, the DON confirmed nursing staff had the ability to send a referral to OT requesting a screening/evaluation for potential positioning concerns, and should have. On 7/31/13, at 2:19 p.m. the DON stated if R4 was uncomfortable in her wheelchair it would be appropriate for nursing to request another OT screening/evaluation for proper positioning.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with ambulation cares for 1 of 3 residents (R3) in the sample who were on an ambulation program. Findings include: R3 was admitted to the facility on 10/14/2002, with the diagnosis of dementia, Alzheimer's disease, and osteoarthrosis. The quarterly Minimum Data Set (MDS) dated 7/16/13 indicated	F 311	F311 a. 8/13/2013 PT saw Resident 3 to evaluate ambulation program. Due to resident's fluctuating abilities ambulation should be attempted 3-6 times a week with the distance as able. Resident 3's plan of care was update to reflect this evaluation. b. 8/2/2013 all rehab nursing programs were compared with plan of care to assure that plan of care was up to date. All other residents' plans of care were accurate. c. 8/29/2013 staff meeting was held and education was given to all staff regarding communicating changes in resident's abilities so that the plan of care remains up-to-date. Education was also provided on the importance of accurate documentation which reflects actual care provided.	8/29/13

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 _____	08/01/2013

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 311	Continued From page 14 R3 was cognitively impaired and required extensive assist with transfers and ambulation. R3's Activities of Daily Living (ADL) Care Area Assessment (CAA)0 dated 5/3/13, indicated R3 required extensive assist of two with transfers and ambulation. The CAA also indicted R3 ambulated in the hallway. Physical Therapy Evaluation screening dated 6/11/13, indicated R3 had upper and lower extremity range of motion (ROM) limitations. The form also indicated R3 required maximum assist of two staff for transfers and ambulation with the ability to tolerate only few steps at a time. The physical therapy plan directed staff to continue with the same exercise program three times a week which included ambulation distance of a few feet. The plan of care (POC) dated 7/3/13, indicated R3 had a mobility deficit, was at high risk for falls and directed staff to provide extensive assistance with ambulation. The POC indicated R3 would continue to walk 100-200 feet with limited staff assistance. Review of R3's ROM Flowsheets for ambulation distance revealed the following: -2/1/13 to 2/28/13, directed staff to ambulate R3 twice a day, without a specific distance indicated. All morning dates were signed except one and 10 signatures were noted for the evening shifts. -3/1/13 to 3/31/13, directed staff to ambulate R3 twice a day without a specific destination goal. The sheet indicated R3 ambulated 50 feet nine days, 25 feet one day, 9 days are not	F 311	d. DON will audit weekly to assure that plan of care is being followed. Will discuss audit findings weekly at IDT. When audits reach 100% compliance for 3 consecutive months will decrease audits to monthly and quarterly with continued compliance. Will discuss quarterly at Quality Assurance meetings. e. 8/29/2013	8/29/13

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 _____	08/01/2013

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 311	Continued From page 15 documented, and all other dates are signed with no distance. -4/1/13 to 4/30/13, directed staff to ambulate R3 twice a day without a specific destination goal. The sheet indicated 28 of 30 day shift entries were signed with no distance indicated. The evening shift eight of 30 evening shift entries were signed with no distance documented. -5 /1/13 to 5/30/13, all day shift entries were signed with no distance documented. The sheet indicated R3 ambulated once daily. -6/1/13-6/30/6/29/13, 28 of 30 days are signed, no ambulation distance was documented. The sheet indicated R3 ambulated once daily. -7/1/13-7/31/13, 30 of 31 days are signed, no ambulation distance is documented. The sheet indicated R3 ambulated once daily. The Seven day assessment tool dated 7/8/13-7/14/13, indicated R3 required extensive assist with transfers. The tool also indicated R3 did not walk in the hall or in room, during the seven day assessment. On 7/30/13, at 8:00 a.m. R3 was observed seated in a wheel chair in the dining room. At 9:09 a.m. R3 was observed to be transferred by two nursing assistants to a recliner in the day room. R3 was not observed to ambulate at this time. On 7/30/13, at 2:31 p.m. R3 was observed seated in the recliner in the day room. At 3:22 p.m. R3 was observed to be transferred by nursing assistants (NA)-D and NA-F into a wheelchair. R3 was not ambulated at this time.	F 311		

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 _____	08/01/2013

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 311	Continued From page 16 On 7/31/13, at 7:12 a.m. R3 was observed asleep in the recliner, in the day room. At 7:51 a.m. R3 was observed to be transferred into a wheelchair by NA-B and licensed practical nurse (LPN)-A. R3 was observed to remain seated in her wheel chair in the dining room from 8:05 a.m. to 9:22 a.m. On 7/31/13, at 9:27 a.m. NA-B and LPN-A was observed to transfer R3 to the toilet and then back to her wheel chair. R3 was not ambulated during this time. On 7/31/13, at 10:05 a.m. NA-E stated R3 was no longer able to ambulate. NA-E added, it had been several months since R3 was last ambulated. On 7/31/13, at 12:45 p.m. NA-B stated R3 had not independently stood up for a few months. NA-B further stated R3 had not walked for at least five months. Additionally, NA-B stated she was not sure why R3 was not ambulating, sometimes R3 would be resistive to cares, "but if we come back later or visit with her she is ok". On 8/1/13, at 9:03 a.m. surveyor requested NA-C to ambulate R3. NA-C and NA-E ambulated resident 25 feet with the use of a rolling walker, after utilizing the restroom, the resident was ambulated another 25 feet. R3 was then assisted to her wheelchair. On 8/1/13, at 9:05 a.m. NA-E, (rehab aide) stated nursing was responsible to ambulated R3 as she provided the ROM services. On 8/1/13, at 11:46 a.m. registered nurse (RN)-B verified R3's care plan indicated R3 should	F 311		

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 _____	08/01/2013

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 311	Continued From page 17 ambulate 100-200 feet at a time, with a wheeled walker. RN-B, stated she had thought she had "seen R3 walk." RN-B stated staff should be reporting to her if R3 was not ambulating. RN-B further stated staff "should be walking R3." On 8/1/13, at 11:57 a.m. the director of nursing (DON) verified R3's POC was not updated to reflect her current abilities, however, stated staff were expected to follow the POC as directed and report changes in residents abilities to the charge nurse.	F 311		
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	F329 a. 8/2/2013 plan of care was updated to reflect parameters of use in which PRN Xanax was to be administered to Resident 22. Also added to plan of care was identification of non-pharmacological interventions to attempt prior to the administration of the PRN medication. DON reviewed documentation for Resident 13 after decrease in Midday Seroquel. On 7/18/2013 in addition to provided documentation in summary of deficiencies in the 11:30 p.m. note regarding hallucinations and reaching out at air in front of her Resident was also reaching out by her feet. Staff gave Resident 13 a baby doll to hold to prevent her from falling from leaning forward in chair. Also the nurse's note added that Resident was resistive and combative with HS cares. On 7/19/2013 in addition to provided documentation in summary of deficiencies in the 10:00 a.m. nurse's note reads, "Resident very resistive with AM bath. Hollering out and hitting out. Very difficult to redirect." In the 7/20/2013 nurse's note at 3:00 am there is indication of increased crying by Resident 13. 7/20/2013 at 2:00 p.m. nurses note indicates Resident 13 "was doing a lot of swearing while walking." 7/21/2013 at 2:30 a.m. nurses note reflects crying has increased. 7/21/2013 at 2:00 p.m. nurses note states,	8/29/13

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 _____	08/01/2013

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 329	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to identify parameters for the use of as needed (PRN) anti-anxiety medication for 1 of 1 resident (R22) reviewed. In addition, the facility failed to identify non-pharmacological interventions attempted prior to increasing anti-psychotic medication for 1 of 3 residents (R13) reviewed who received anti-psychotic medications. Findings include: R22's diagnoses included dementia, non-organic psychosis, agitation and dementia with behavioral disturbances. The quarterly Minimum Data Set (MDS) dated 6/9/13, indicated R22 had severe cognitive impairment and also indicated R22 moved and spoke slowly. The MDS did not identify any other mood or behavioral disturbances. The plan of care (POC) dated 12/20/12, indicated R22 as required anti-anxiety medication for the treatment of dementia, paranoia, anxiety, wandering, elopement and dementia. The POC directed staff to administer medications as ordered. The POC lacked identification of the parameters of use in which the PRN medication was to be administered The plan also lacked identification of non-pharmacological interventions to attempt prior to the administration of the medication. The Physician Order Report dated 6/14/13,	F 329	"Crying with AM cares, resistive, mean, scratching. Fax sent to psychiatrist. Ate well. Mood very negative." Since medication was resumed at regular dose mood has improved greatly. Is pleasant and laughing with staff with no further crying noted. b. 8/2/2013 each residents plan of care was reviewed to assure that there were parameters for use and identified non-pharmacological interventions listed to attempt prior to use of PRN psychotropic medications. c. The consultant pharmacist will continue to perform medication reviews monthly, continuing to ensure that each resident is 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. The consultant pharmacist's medication review, will include by not limited to reviewing the patient's care plan, nurses notes, and/or physician progress notes/history and physical for parameters established for non-pharmacological interventions tried prior to initiating or administering "as needed" medication therapy. (including anti-anxiety agents)	

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 _____	08/01/2013

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 329	Continued From page 19 indicated an order for Xanax (anti-anxiety medication) 0.5 milligrams (mg) to be administered three times a day and every six hours PRN. The PRN Medication Notes (medication record) for 7/13, revealed on 7/28/13, R22 received a PRN dose of Xanax 0.5 mg at 2:20 a.m. for increased anxiety. The efficacy of the PRN medication was not documented. Resident Care Notes dated 7/28/13, indicated R22 had been upset after receiving bedtime cares. The note also indicated R22 had been yelling at the staff and following them into other resident rooms. The note lacked indication of non-pharmacological interventions attempted prior to the administration of Xanax. On 7/31/13, at 1:20 p.m. the director of nursing (DON) stated R22's displayed behaviors such as hallucinations, calling staff members by a different name, yelling, swearing, resistive to cares and striking out at staff. The DON confirmed R22 received Xanax three times a day and could receive an additional dose as needed. She stated the staff should have attempted non-pharmacological interventions prior to the administration of the PRN medications. The DON also confirmed the facility had not established parameters for the use of the medication. Review of the Medication Administration policy dated 10/09, directed the staff to document any further information in nursing notes, including the reason the medication was given, results of the medication and any side effects of PRN medications. The policy did not address the use	F 329	Patients whose comprehensive assessment has determined that they have a diagnosis of a specific condition documented in the clinical record, may have current need for antipsychotic medications. Gradual dose reductions and behavioral interventions, unless clinically contraindicated, will be performed in an effort to discontinue these drugs. If a patient adversely reacts to a dosage reduction, with behavior issues or other documented issues, parameters established for non-pharmacological interventions need to be tried and documented prior to increasing the medication back to its original dosage. After a medication is given in an "as needed" situation, documentation of the outcome should be made and reviewed prior to future incidents that may require non-pharmacological interventions prior to further medication administration. 8/29/2013 the medication administration policy was updated to include addressing the use of non-pharmacological interventions prior to administration of "as needed" medications. All nursing staff reviewed and understood changes to policy d. DON will audit weekly PRN medication use to assure that parameters are being followed and non-pharmacological interventions are provided prior to medications and are being documented. Will discuss audit findings weekly at IDT. When audits reach 100% compliance for 3 consecutive	

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 _____	08/01/2013

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 329	Continued From page 20 of non-pharmacological interventions prior to the administration of PRN medications. R13's diagnoses included Alzheimer's dementia with behavioral disturbances and depression. The quarterly MDS dated 5/10/13, indicated R13 had severe cognitive impairment and displayed hallucinations. The MDS did not identify R13 as having any other type of mood or behavioral problems. The POC updated on 5/23/13, indicated R13 had depression and dementia with behavioral disturbances. The POC directed staff to ensure R13 received the lowest effective dose of medications. The Physician Order Report printed on 7/2/13, indicated an order for Seroquel (an anti-psychotic medication) for the treatment of dementia with behavioral disturbances. The order indicated R13 was to receive 50 mg in the morning, 100 mg at mid day (2:00 p.m.) and 200 mg at bedtime. The report further indicated on 7/17/13, the psychiatrist lowered the midday dose of Seroquel to 50 mg. A fax communication form dated 7/21/13, the staff communicated to the psychiatrist, "Since reduction 7/17- resident has become much more resistive, mean, scratching, swearing, whimpering with cares. What are your thought on putting it (the Seroquel) back to what it was." On 7/22/13, the psychiatrist resumed the midday dose to 100 mg daily. Review of the Resident Care Notes (nurses notes) revealed the following information:	F 329	months will decrease audits to monthly and quarterly with continued compliance. Will discuss quarterly at Quality Assurance meetings. e. 8/29/2013	8/29/13

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 _____	08/01/2013

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 329	Continued From page 21 - 7/17/13, Seroquel decreased. - 7/18/13, 5:40 p.m. no changes noted with mood or behavior. -7/18/13, 11:30 p.m. no adverse reaction to medication change. Experienced some hallucinations, talking to self and reaching out in front of her. smiling and making kissing noises. -7/19/13, at 10:00 a.m. resistive to morning bath, difficult to redirect -7/20/13, at 3:00 a.m. Seroquel order decreased no side effects. No problems with cares. -7/21/13 at 2:50 a.m. resident crying and whimpering in her room, eats everything at meals. -7/21/13. at 2:00 p.m. resident slightly resistive with cares. Fax sent to psychiatrist. The nurses notes lacked an assessment to justify the increase of Seroquel and also lacked identification of non-pharmacological interventions attempted prior to contacting the physician for an increase in the medication. The nursing assistant Monitoring Form For Behaviors between 7/17/13 - 7/22/13, indicated the nursing assistants had not identified any behaviors. On 8/1/13, at 7:00 a.m. registered nurse (RN)-B confirmed the clinical record lacked documentation related to the use of non-pharmacological interventions prior to resuming the previous dose of Seroquel. RN-B stated the non-pharmacological interventions should have been recorded on the behavior monitoring sheets. On 8/1/13, at 11:16 a.m. the DON reviewed the behavior sheets and confirmed the facility had not	F 329		

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 _____	08/01/2013

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 329	Continued From page 22 identified R13's behaviors nor the use of non-pharmacological interventions attempted prior to increasing the medication.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced	F 356	F356 a.7/31/2013 Posting Direct Care Daily Staffing Numbers policy was adopted and procedure was put into use 8/1/2013. b. By following the policy adopted 7/31/2013 all necessary information will be publicly visible per regulations. c. 7/31/2013 Posting Direct Care Daily Staffing Numbers policy was adopted and posted for all nursing staff to review. The procedure was put into use 8/1/2013. d. DON will complete audits weekly to assure that the direct care daily staffing numbers are being posted per policy. Will discuss audit findings weekly at IDT. When audits reach 100% compliance for 3 consecutive months will decrease audits to monthly and quarterly with continued compliance. Will discuss quarterly at Quality Assurance meetings. e. 8/1/2013	8/1/13 8/1/13

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 _____	08/01/2013

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 356	Continued From page 23 by: Based on observation and interview, the facility did not ensure accurate nurse staffing information was readily accessible and updated daily for residents and visitors as required. This had the potential to effect all 21 of 21 residents residing in the facility. Findings include: On 7/29/13, at 2:00 p.m. the nurse staffing posting was observed on the wall in a clear holder, across from the nurse's desk. The completed form was dated 7/23/13. On 7/30/13, at 8:10 a.m. the nurse staffing posting was observed on the wall in a clear holder, across from the nurse's desk. The completed form was dated 7/29/13. On 7/31/13, at 7:45 a.m. the same nurse staffing posting dated 7/29/13, remained posted on the wall in a clear holder, across from the nurse's desk. On 7/31/13, at 11:45 a.m. the director of nursing (DON) stated she was responsible to update to nurse posting information. The DON verified the nurse staff posting information was not updated each shift nor was posted for the current date. The DON stated on weekends the nurse staff postings were not updated. Instead, she verified the actual hours worked when she returned following Monday. The DON stated she completed the nurse staffing postings after the schedule was complete and currently had the nurse staffing postings completed through 8/15/13. DON reported she needed to review/revise the facility policy on nurse staffing	F 356		

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 _____	08/01/2013

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 356	Continued From page 24 postings.	F 356		
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 and interview, the facility failed to maintain the kitchen and cooking equipment in a clean and sanitary manner. In addition, the facility failed to label, cover and date food items in order to prevent the spread of food borne illness. This practice had the potential to effect all 21 of 21 residents who resided in the facility. Findings include: During the kitchen sanitation tour on 7/31/13, at 1:13 p.m. with the dietary manager (DM), the following concerns were noted: The large Freezer: -Four-four pound containers of soup with approximately 50% of each remaining. The containers were uncovered, not dated nor labeled. -Eight-eight pound bags of frozen soup were not	F 371	F371 a. Dietary staff properly labeled and dated items being stored in the freezer and refrigerator. At this time cleanliness of other kitchen areas was ensured as well. b. On 8/7/13 dietary staff completed a sanitary survey for the kitchen area. c. On 8/13/13 a dietary staff meeting was held. At this meeting state survey results were discussed and education was given on proper sanitation, proper hand washing, labeling of food in storage areas, daily cleaning schedules, and weekly cleaning schedules. d. Each month a different dietary employee will conduct a sanitation survey and results will be discussed at the following monthly meeting. Dietician will report these results at IDT meetings as well as quarterly at Quality Assurance meetings. e. 8/13/13	8/13/13 8/13/13

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 _____	08/01/2013

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 371	Continued From page 25 dated or labeled -One-five pound bag of bean soup which was not dated, -One bag of link sausages, not secured, labeled or dated, -One bag of chicken bites, not labeled or dated, -One bag of chicken patties and a bag beef patties, not dated or labeled, -One package of an unknown food with aluminum foil wrapping, not dated or labeled, and -One plastic container labeled "pureed meats" which contained four-Ziploc's bags of pureed meat, not labeled or dated. The refrigerator: -Two-five gallon buckets of pickles, opened, not dated. -One large white container which contained 20 bread slices and two bags of buns, not labeled or dated. On 7/31/13, at 2:00 p.m., the DM verified that all food in the freezers and refrigerators were expected to be labeled, dated and securely wrapped. On 7/31/13, at 2:20 p.m., the licensed dietician (LD) stated all food was expected to be securely wrapped, dated and labeled when being stored in the refrigerator and freezers. On 7/31/13, at 2:24 p.m., a fry pan was observed with thick black matter on the cooking surface. Cook (C)-1 verified the finding and stated the fry pan was not suitable for cooking and stated she would throw it out. On 7/31/13, at 2:28 p.m., the range hood crevices was observed to have gray matter on them. C-1	F 371		

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 _____	08/01/2013

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 371	Continued From page 26 verified the finding and stated the hood was cleaned every two weeks, however, also stated it possibly needed to be cleaned more often. On 7/31/13, at 2:30 p.m., the DM verified the stove hood was dirty and needed to be cleaned. On 7/31/13, at 2:35 p.m., the floor drains throughout the kitchen were observed to contain a black substance. The DM verified the drains were not clean. The DM stated that the drains were to be cleaned weekly, but "[They] may need to be cleaned more often." On 7/31/13, at 2:40 p.m. the floor beneath the steam cooker was observed with thick, black matter. Ten ceramic floor tiles in the food preparation area were observed to be broken with grout missing. In addition, tiles and grout were also missing from below the steam kettle located in the cooking area. The DM verified the floors were unclean and in need of repair. The DM stated staff were expected to clean the floors daily and was also unaware of any facility plans to replace the tiles or grouting.	F 371		
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	F428 a. 8/2/2013 plan of care was updated to reflect parameters of use in which PRN Xanax was to be administered to Resident 22. Also added to plan of care was identification of non-pharmacological interventions to attempt prior to the administration of the PRN medication.	8/29/13

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 _____	08/01/2013

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 428	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the registered pharmacist identify irregularities, monitor and recommend parameters for the administration of as needed (PRN) anti-psychotic medication for 1 of 1 resident (R22) in the sample who was receiving PRN anti-psychotic medication. Findings include: R22's diagnoses included dementia, nonorganic psychosis, agitation and dementia with behavioral disturbances. The quarterly Minimum Data Set (MDS) dated 6/9/13, indicated R22 had severe cognitive impairment. The MDS also indicated R22 moved and spoke slowly. The MDS did not identify any other mood or behavioral disturbances. The plan of care (POC) dated 12/20/12, indicated R22 required the use of anti-anxiety medication for the treatment of dementia, paranoia, anxiety, wandering, elopement, and dementia. The POC directed staff to administer medications as order. The POC lacked identification of the parameters in which the PRN medication was to be given. Additionally, the POC lacked identification of non-pharmacological interventions to be attempted prior to administration of the PRN medication nor the parameters in which the medication could be administered. The Physician Order Report dated 6/14/13, indicated an order for Xanax (anti-anxiety medication) 0.5 milligrams (mg) to be	F 428	b. 8/2/2013 each residents plan of care was reviewed to assure that there were parameters for use and identified non-pharmacological interventions listed to attempt prior to use of PRN psychotropic medications. c. The consultant pharmacist reviews each patient's medical record monthly. The pharmacist will identify irregularities, including "as needed" antipsychotic medication identified irregularities. The pharmacist will review the medical record for parameters for identifying the need to attempt non-pharmacological interventions prior to the administration of "as needed" anti-anxiety medication. If the resident does not have such parameters, the consultant pharmacist will identify such irregularities in their Drug Regimen Review, Report of Irregularities, to act upon 8/2/2013 DON and RiverView Pharmacy Manager reviewed the Pharmacy Procedure Manual for RiverView Long Term Care Facility. 8/29/2013 the medication administration policy was updated to include addressing the use of non-pharmacological interventions prior to administration of "as needed" medications. All nursing staff reviewed and understood changes to policy. d. RiverView Pharmacy Manager will do random drug regimen audits after monthly audits are done. Will discuss audit findings when completed at IDT. When audits reach 100% compliance for 3 consecutive months will decrease audits to	

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 _____	08/01/2013

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 428	Continued From page 28 administered three times a day and every six hours as needed (PRN). The PRN Medication Notes (medication record) for July 2013, indicated on 7/28/13, R22 had received Xanax 0.5 mg at 2:20 a.m. for increased anxiety. The space to document the results of the medication was blank. The Resident Care Notes dated 7/28/13, indicated R22 had been upset after receiving bedtime cares. The note also indicated R22 had been yelling at the staff and following them into other resident rooms. The note had not indicated any type of non pharmacological interventions which had been attempted prior to the administration of the medication. On 7/31/13, at 1:20 p.m. the director of nurses (DON) stated R22 had displayed behaviors which included hallucinations, calling staff members by a different name, yelling, swearing, resistive to cares and striking out at staff. The DON confirmed R22 received Xanax three times a day and could receive an additional dose as needed. She stated staff were to attempt non-pharmacological interventions prior to the administration of the PRN medications. However, the DON confirmed the facility had not established parameters for the use of the medication. Review of the Medication Administration policy dated 10/2009, directed staff to document any further information in the nurse's notes such as the reason for which the med was given and any side effects of PRN medications. The policy did not address the use of non-pharmacological interventions prior to the administration of PRN	F 428	quarterly with continued compliance. Will discuss quarterly at Quality Assurance meetings. e. 8/29/2013	8/29/13

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 _____	08/01/2013

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 428	Continued From page 29 medications. Review of the Pharmacist's Report of Pharmaceutical Services For the Riverview Nursing Home from 1/2013 - 7/2013, did not identify the need to attempt non-pharmacological interventions prior to the administration of PRN anti-anxiety medication. On 8/1/13, at 8:30 a.m. the consultant pharmacist confirmed he had not identified the documentation irregularity related to the identification of non-pharmacological interventions to be attempted prior to the administration of the PRN medication nor identified the lack of established parameters for the use of the PRN medication.	F 428		

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 _____	08/01/2013

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 159	Continued From page 2 most recent one having been sent in 4/13. The patient account representative provided a copy of the most recent statement sent to FM-B. Upon review, R9's Resident Trust Fund Statement was dated 1/2/13. The patient account representative confirmed this was the most recent quarterly personal funds account statement and that no statement had been sent to FM-B in 4/13.	F 159		
F 170 SS=C	483.10(l)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to ensure mail was delivered to the residents on Saturdays. This practice had the potential to affect all 21 of 21 residents who resided in the facility. Findings include: On 7/30/13, at 11:32 a.m. social service designee (SSD)-A confirmed that since 11/12, the facility had not delivered mail to the residents on Saturdays.	F 170		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241	F241 a. Resident 3 had been wearing transfer belt continuously when up in chair per her plan of care and with consent from her daughter/POA. 8/2/2013 @ 0600 continuous use of transfer belt when Resident 3 was up was discontinued. Transfer belt was applied and used for all transfers and ambulation. Resident was very resistive to the application of the transfer belt and	9/12/13

Addendum
recieved 9/13/13
SBurkmeier

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 _____	08/01/2013

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 241	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to remove personal care equipment after use for 1 of 2 residents (R3) reviewed for dignity. Findings include: R3's diagnoses included dementia, Alzheimer's disease and osteoarthrosis. The quarterly Minimum Data Set (MDS) dated 7/16/13, indicated R3 was cognitively impaired and required extensive assist with bed mobility, transfers and ambulation. The Activities of Daily Living (ADL) Care Area Assessment (CAA) dated 5/3/13, indicated R3 required extensive assist of two for bed mobility, transfers, toileting, and ambulation. The CAA also indicated R3 required total assist with locomotion. The plan of care (POC) dated 7/3/13, indicated R3 was at risk for falls and directed staff to leave the transfer belt loosely on R3 at all times as R3 was quick to stand and attempt to move without assistance. During observations on 7/29/13, from 5:25 p.m. to 7:22 p.m. R3 was observed seated in her wheelchair in the dining room, eating her supper meal. R3 was noted to have a transfer belt on around her waist. On 7/30/13, at 8:00 a.m. R3 was observed seated in a wheelchair in the dining room, again wearing a transfer belt around her waist. At 9:09 a.m., R3 was observed to be transferred by two nursing	F 241	pushed body back into the chair upon each application. The repetitive application made Resident 3 very angry. Interventions were attempted to reduce this action by Resident 3 as bruising and self injury were a risk with this action. No interventions were successful and action was continued with each application of transfer belt. 8/3/2013 Resident 3 attempted to stand up from wheelchair x2. Staff was near and able to assist Resident 3 to sit down before attempted self transfer resulted in fall. Without transfer belt to use there was an increased possibility for injury to both Resident 3 and staff members. 8/4/2013 upon assessment by Resident Care Coordinator the increased anger and behaviors that repetitive application of transfer belt caused combined with the increased risk of injury presented when transfer belt was not able to be applied warranted the decision to again implement the use of continuously wearing transfer belt when up in chair. Daughter was consulted and agreed with assessment and plan of care was updated. b. There are 8 other residents who have it in the plan of care to wear transfer belt continuously when up in chair. Family has consented to this as well. Assessments were completed by the Resident Care Coordinator & DON 8/2/2013 and all 8 continue to warrant this as a fall reduction intervention. c. 8/22/2013 the Staff Use of Transfer Belts policy was reviewed by DON and found to be adequate and relevant. 8/23/2013 The Fall	

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 _____	08/01/2013

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 241	Continued From page 4 assistants (NAs) to a recliner in the day room. The transfer belt was left around R3's waist. R3 was observed on 7/30/13, at 2:31 p.m. seated in a recliner in the day room with the foot rest elevated. The transfer belt was noted to be around her waist. At 3:22 p.m., R3 was observed to be transferred by NA-D and NA-F to a wheelchair. The belt was again left around her waist after the transfer. On 7/31/13, at 7:12 a.m. R3 was observed to be asleep in a day room recliner. The transfer belt was observed to be around her waist. At 7:51 a.m., R3 was observed to be transferred to a wheelchair by NA-B and licensed practical nurse (LPN)-A. The transfer belt was again left around her waist. From 8:05 a.m. to 9:22 a.m., R3 was observed seated in her wheelchair, in the dining room. At 9:27 a.m., NA-B and LPN-A transferred R3 to the toilet and then back to her wheel chair. Though cares and transferring were completed, the transfer belt remained around R3's waist. On 8/1/13, at 9:03 a.m. NA-C stated R3 did not stand and no longer required a transfer belt to be left on at all times. On 8/1/13, at 11:46 a.m. RN-B verified R3 had a history of self ambulation and falls therefore, the transfer belt was kept on R3 as a fall prevention intervention. However, RN-B confirmed R3 no longer walked independently and stated she no longer needed the transfer belt left on in between use. On 8/1/13, at 11:57 a.m. the DON verified that R3 was not ambulating or transferring without assist and did not require a transfer belt to be worn	F 241	Prevention Program policy was updated to include the "use of continuous use of transfer belts when up in chair when the risk of falls from sudden attempts to stand are present" as an intervention that may be implemented in the fall prevention program. This policy also gives direction as to the systematic review of all interventions placed for fall prevention to assure individualized programs remain appropriate based on individual needs. A long term plan to reduce usage of gait belts has been put in place on 8/29/2013 these policies were reviewed by all staff. A long term plan to reduce usage of transfer belts has been put in place on 9/11/13. This plan adds attempts to self ambulate in daily behavioral charting for residents. If none or minimal attempts are made by residents to self ambulate transfer belts for those particular residents will then be discontinued. d. DON will audit weekly to assure that plan of care is being followed, Fall Prevention Programs are being reviewed per policy, and continued assessment of transfer belt need is conducted. Will discuss audit findings weekly at IDT. When audits reach 100% compliance for 3 consecutive months will decrease audits to monthly and quarterly with continued compliance. Will discuss quarterly at Quality Assurance meetings. e. 9/12/2013	9/12/13

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 _____	08/01/2013

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 241	Continued From page 5 outside of transfers.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based observation, Interview and document review, the facility failed to ensure the morning routines of each resident, matched those of their previous lifestyle, for 1 of 3 residents (R8) whose morning cares were provided during the overnight shift. Findings include: R8's diagnoses included Alzheimer's disease, dementia with behavioral disturbances and depression. The quarterly Minimum Data Set (MDS) dated 7/7/13, indicated R8 had severe cognitive impairment and required total staff assistance for all activities of daily living. The plan of care revised 7/11/13, indicated R8 was non-verbal and directed staff to assist R8 with all activities of daily living. On 7/31/13, at 7:13 a.m. R8 was observed resting in her bed, fully dressed. At 8:00 a.m., nursing assistant (NA)-C and NA-E assisted R8 from her	F 242	F242 a. 4/29/2013 & 7/18/2013 Nurse Leader Rounding was performed face to face with Resident 8's Family Member A. On both occasions Family Member A was asked "Does the staff honor Resident 8's preferences and previous life routines, such as when to get up and go to sleep or when to take a bath?" On both occasions she answered yes. 8/9/2013 the Social Service Designee spoke with Family Member A regarding getting Resident 8 dressed and left in bed at 5:30 AM. Family Member A stated that State Surveyors told her that Resident 8 was being gotten out of bed at that time. Family Member A indicated that it was ok with her if her mom was washed and dressed at 5:30 AM and then left in bed to sleep until breakfast. This has been Resident 8's routine for the last 5 years. Staff were informed of Family Member A's choice. b. 8/5/2013 all Nurse Leader Rounding logs were reviewed since beginning of implementation 2/28/2013 and all residents logs indicated that all families/responsible parties had answered yes to the question, "Does the staff honor Resident's name preferences and previous life routines, such as when to get up and go to sleep or when to take a bath?"	9/6/13

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 _____	08/01/2013

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 242	Continued From page 6 bed to the wheelchair via a full body mechanical lift. NA-C stated R8 had received morning cares by the night shift staff at approximately 4:30 a.m. On 7/31/13, at 8:26 a.m. licensed practical nurse (LPN)-A verified night shift staff typically completed R8's morning cares at approximately 5:00 a.m. each morning. On 7/31/13, at 10:00 a.m. family member (FM)-A stated R8 had worked out of the home previous to her stay at the facility and typically woke up between 6:00 a.m. and 7:00 a.m. FM-A stated she was aware R8 was receiving cares by the night staff because she understood it was necessary to help the day shift staff members with their morning duties. When asked if R8 routinely dressed before 5:30 a.m. FM-A stated at no time during R8's life had she routinely dressed before 6:00 a.m. FM-A added she could not recall the staff members asking permission or the family's input on providing care for R8 before 6:00 a.m. Review of the clinical record lacked a history of R8's previous life routine to include her customary morning routine. On 8/1/13, at 5:35 a.m. R8 was observed lying in bed, fully dressed. On 8/1/13, at 5:36 a.m. NA-F stated she had assisted R8 to dress around 5:00 a.m. NA-F also stated the night shift was assigned to assist three residents with morning cares prior to leaving at 7:00 a.m. and verified R8 was routinely provided morning cares at 5:00 a.m. On 8/1/13, at 7:10 a.m. registered nurse (RN)-B	F 242	c. Social Service Designee will update all residents Social Service Assessment and Social History to address and ensure accuracy of "Usual Daily Routine". Plan of care will then be updated to reflect resident chosen daily routine. RiverView Care Center Admission Assessment Policy/Procedure updated to indicate how to communicate previous daily routine to all staff to ensure preferences are honored. As of 9/6/13 Social Services Designee has contacted all family members for consent on both morning wake times and nature of cares provided. Daily routines of residents have been confirmed and remain the same for all but one resident in respect to these discussions. d. DON will audit weekly to assure that plan of care is being followed and preferences on daily routine are honored. Will discuss audit findings weekly at IDT. When audits reach 100% compliance for 3 consecutive months will decrease audits to monthly and quarterly with continued compliance. Will discuss quarterly at Quality Assurance meetings. e. 9/6/2013	9/6/13 JM

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 _____	08/01/2013

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 242	Continued From page 7 confirmed R8 received morning cares daily by the night staff. RN-B stated she did not know how R8 had been chosen to receive early morning cares during the night shift "last rounds," which typically took place around 5:00 a.m. RN-B was unaware of R8's customary routine prior to residing at the facility and to her knowledge, R8's family members had not been asked about her previous life routine. On 8/1/13, at 7:25 a.m. NA-F (night shift NA) stated she had been instructed to assist three residents in the morning with cares before leaving the facility at 7:00 a.m. At 7:58 a.m. the social service designee (SSD) stated she had not been involved with choosing which residents received early morning cares. She confirmed getting dressed before 5:30 a.m. could be considered early and the residents customary routines should have been taken into consideration. The facility did not have policy regarding customary routines and the daily schedules of the residents.	F 242		
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	F 280		

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 _____	08/01/2013

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 356	Continued From page 24 postings.	F 356		
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 and interview, the facility failed to maintain the kitchen and cooking equipment in a clean and sanitary manner. In addition, the facility failed to label, cover and date food items in order to prevent the spread of food borne illness. This practice had the potential to effect all 21 of 21 residents who resided in the facility. Findings include: During the kitchen sanitation tour on 7/31/13, at 1:13 p.m. with the dietary manager (DM), the following concerns were noted: The large Freezer: -Four-four pound containers of soup with approximately 50% of each remaining. The containers were uncovered, not dated nor labeled. -Eight-eight pound bags of frozen soup were not	F 371	F371 a. Dietary staff properly labeled and dated items being stored in the freezer and refrigerator. At this time cleanliness of other kitchen areas was ensured as well. b. On 8/7/13 dietary staff completed a sanitary survey for the kitchen area. c. On 8/13/13 a dietary staff meeting was held. At this meeting state survey results were discussed and education was given on proper sanitation, proper hand washing, labeling of food in storage areas, daily cleaning schedules, and weekly cleaning schedules. d. Each week a different dietary employee will conduct a sanitation survey and report results to dietary manager. Upon four consecutive weeks of compliance, surveys will be conducted biweekly for four weeks and then reduced to monthly. Results will be discussed at the monthly dietary meetings. Dietician will report these results at weekly IDT meetings as well as quarterly at Quality Assurance meetings. e. 9/12/13	9/12/13 9/12/13 JM

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 _____	08/01/2013

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 371	Continued From page 25 dated or labeled -One-five pound bag of bean soup which was not dated, -One bag of link sausages, not secured, labeled or dated, -One bag of chicken bites, not labeled or dated, -One bag of chicken patties and a bag beef patties, not dated or labeled, -One package of an unknown food with aluminum foil wrapping, not dated or labeled, and -One plastic container labeled "pureed meats" which contained four-Ziploc's bags of pureed meat, not labeled or dated. The refrigerator: -Two-five gallon buckets of pickles, opened, not dated. -One large white container which contained 20 bread slices and two bags of buns, not labeled or dated. On 7/31/13, at 2:00 p.m., the DM verified that all food in the freezers and refrigerators were expected to be labeled, dated and securely wrapped. On 7/31/13, at 2:20 p.m., the licensed dietician (LD) stated all food was expected to be securely wrapped, dated and labeled when being stored in the refrigerator and freezers. On 7/31/13, at 2:24 p.m., a fry pan was observed with thick black matter on the cooking surface. Cook (C)-1 verified the finding and stated the fry pan was not suitable for cooking and stated she would throw it out. On 7/31/13, at 2:28 p.m., the range hood crevices was observed to have gray matter on them. C-1	F 371		

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 _____	08/01/2013

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 371	Continued From page 26 verified the finding and stated the hood was cleaned every two weeks, however, also stated it possibly needed to be cleaned more often. On 7/31/13, at 2:30 p.m., the DM verified the stove hood was dirty and needed to be cleaned. On 7/31/13, at 2:35 p.m., the floor drains throughout the kitchen were observed to contain a black substance. The DM verified the drains were not clean. The DM stated that the drains were to be cleaned weekly, but "[They] may need to be cleaned more often." On 7/31/13, at 2:40 p.m. the floor beneath the steam cooker was observed with thick, black matter. Ten ceramic floor tiles in the food preparation area were observed to be broken with grout missing. In addition, tiles and grout were also missing from below the steam kettle located in the cooking area. The DM verified the floors were unclean and in need of repair. The DM stated staff were expected to clean the floors daily and was also unaware of any facility plans to replace the tiles or grouting.	F 371		
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		

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

F52510 33

PRINTED: 08/20/2013
FORM APPROVED
OMB NO. 0938-0391

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 _____	**07/31/2013**

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
K 000	INITIAL COMMENTS	K 000		

DC: 09/10/2013

EXIT: 08/01/2013

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN 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. At the time of this survey RiverView Nursing Home 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101

Or by e-mail to:

RECEIVED
SEP 9 2013
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

POC ok
9-13-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
John Mella	Administrator	8/30/13

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
	245251	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**07/31/2013**

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
K 000	Continued From page 1 Marian.Whitney@state.mn.us and Barbara.Lundberg@state.mn.us Fax Number 651-215-0525 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 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	K 000		

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 _____	**07/31/2013**

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
K 000	Continued From page 2 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 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 64 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 NOT MET as evidenced by:	K 000		
K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations it was determined that the 2-hour fire barriers are not in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.1.1.4.1. This deficient practice could allow the products of combustion to travel	K 011	**K011** a. Unsealed conduits along the east and west 2-hour fire barriers were sealed. Rooms 624 and 625 have been checked to verify all penetrations are sealed. b. Conduits were left unsealed during a previous construction project. Past construction projects will be inspected to ensure all penetrations were sealed. c. Plant services staff will inspect future construction projects to ensure all penetrations are sealed.	8/22/13

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 _____	**07/31/2013**

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
K 011	Continued From page 3 from one building to another, which could negatively impact all 24 residents in a fire emergency. Findings include: During the facility tour on 07/31/13, between 11:00 am and 1:00 pm, observations by surveyor 03006, revealed that: 1) The east 2-hour fire barrier between the 2003 additon and the 1974 existing building has unsealed conduit sleeves in it above the suspended ceiling in the sleeping rooms, and 2) The west 2-hour fire barrier between the 2003 additon and the 1974 existing building has 2 unsealed conduits and open wiring sleeves through it in rooms 625 and 624. The Director of Maintenance and the Administrator verified these findings of the deficient practice at the time of the inspection and during the exit conference.	K 011	d. Director of Plant Services, Jeffrey R. Orvedal, will monitor construction projects and communicate inspection results to facility. e. 8/22/13	8/22/13