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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: CQNF
Facility ID: 00100

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245254**

2. STATE VENDOR OR MEDICAID NO. (L2) **012198100**

3. NAME AND ADDRESS OF FACILITY
(L3) **REGINA SENIOR LIVING**
(L4) **1175 NININGER ROAD**
(L5) **HASTINGS, MN** (L6) **55033**

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) **01/01/2014**

6. DATE OF SURVEY **09/18/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **06/30**

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

12. Total Facility Beds **61** (L18)

13. Total Certified Beds **61** (L17)

10. THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	61			
(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):

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Unit Supervisor 09/18/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 09/19/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **06/02/1982** (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. **00000** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **09/17/2014** (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5254

Electronically Delivered: September 19, 2014

Ms. Karrie Tipler, Administrator
Regina Senior Living
1175 Nininger Road
Hastings, Minnesota 55033

Dear Ms. Tipler:

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 12, 2014 the above facility is certified for:

61 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 61 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

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 about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: September 18, 2014

Ms. Karrie Tipler, Administrator
Regina Senior Living
1175 Nininger Road
Hastings, Minnesota 55033

RE: Project Number S5254023

Dear Ms. Tipler:

On August 27, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 14, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On September 18, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 12, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 14, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 12, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 14, 2014, effective September 12, 2014 and therefore remedies outlined in our letter to you dated August 27, 2014, 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. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124   Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245254	A. Building B. Wing	9/18/2014

Name of Facility	Street Address, City, State, Zip Code
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	09/12/2014	ID Prefix F0281 Reg. # 483.20(k)(3)(i) LSC	09/12/2014	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	09/12/2014
ID Prefix F0312 Reg. # 483.25(a)(3) LSC	09/12/2014	ID Prefix F0329 Reg. # 483.25(l) LSC	09/12/2014	ID Prefix F0356 Reg. # 483.30(e) LSC	09/12/2014
ID Prefix F0428 Reg. # 483.60(c) LSC	09/12/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/AK	09/18/2014	22580	09/18/2014

Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/14/2014

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

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245254	01 - NURSING HOME	9/12/2014

Name of Facility	Street Address, City, State, Zip Code
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	08/20/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	09/18/2014	25822	09/12/2014
CMS RO				

Followup to Survey Completed on: 8/12/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245254	02 - 2012 ADDITION BLDG	9/12/2014

Name of Facility	Street Address, City, State, Zip Code
REGINA SENIOR LIVING	1175 NININGER ROAD HASTINGS, MN 55033

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	08/20/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	09/18/2014	25822	09/12/2014
CMS RO				

Followup to Survey Completed on: 8/12/2014

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: CQNF
Facility ID: 00100

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245254**
2. STATE VENDOR OR MEDICAID NO. (L2) **012198100**

3. NAME AND ADDRESS OF FACILITY
(L3) **REGINA SENIOR LIVING**
(L4) **1175 NININGER ROAD**
(L5) **HASTINGS, MN** (L6) **55033**

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) **01/01/2014**
6. DATE OF SURVEY **08/14/2014** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

FISCAL YEAR ENDING DATE: (L35) **06/30**

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

12. Total Facility Beds **61** (L18)
13. Total Certified Beds **61** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	61			
(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):

17. SURVEYOR SIGNATURE Date :
Mary Capes, HFE NE II 09/09/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 09/17/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **06/02/1982** (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. **00000** (L31)

30. REMARKS
Posted 09/17/2014 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: August 27, 2014

Ms. Karrie Tipler, Administrator
Regina Senior Living
1175 Nininger Road
Hastings, Minnesota 55033

RE: Project Number S5254023

Dear Ms. Tipler:

On August 14, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**
>
> **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:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Telephone: (651) 201-3793
Fax: (651) 201-3790

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 23, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original

deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 14, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 14, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING ______ B. WING ______	08/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	**1175 NININGER ROAD HASTINGS, MN 55033**

(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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		9/12/14

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

Electronically Signed — 09/05/2014

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

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F 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan with resident specific non pharmacological interventions to assist 1 of 1 resident (R69) to reduce anxiety and promote sleep at night. Findings include: Review of R69's admission Minimum Data Set [MDS], dated 5/15/14 revealed R69 was cognitively intact. Review of R69's Physician Order Report, dated 7/14/14 through 8/14/14 revealed physician orders for scheduled lorazepam 0.25 milligrams (mg) each night for increased anxiety and insomnia, and as needed (prn) lorazepam 0.25 mg was available for insomnia if the scheduled dose was not effective. (Lorazepam is an anti-anxiety medication.) Review of R69's care area assessment, dated 6/9/14, revealed "Res [resident] is on antianxiety and antidepressant as ordered. Dx [diagnoses] depression, anxiety. Staff to monitor for changes, s/e [side effects] effectiveness. Call light w/n [within] reach, proceed to cp [care plan]" Review of R69's care plan revealed a Mood/Behavior section, dated 6/10/14, which noted "Mood/behavior: May be related to: Diagnosis of hearing loss, memory loss, sleep disturbance and depressive disorder, as evidenced by: PHQ-9 (depression screening tool) of 12/27, indicating possible moderate level of depression." A Psychosocial Well-Being section,	F 279	For R69, individualized non pharmacological interventions have been added to the care plan, in addition to the general interventions that were already listed. A house audit will be completed for all residents with orders for PRN psychotherapeutic drugs to ensure that non pharmacological interventions are in place. Ongoing audits will be conducted to ensure that all residents with PRN psychotherapeutic medications have non pharmacological interventions in place and that documentation is complete. Staff will be retrained on appropriate documentation and implementation of non-pharmacological interventions prior to the use of psychotherapeutic medications. All licensed nursing staff will be re-educated regarding the importance of identifying individualized non pharmacological interventions and attempting and documenting their effectiveness prior to administering PRN medications. The consultant pharmacist will include monitoring for irregularities with implementation of updated documentation protocol during monthly medication regimen reviews, and will report any	

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F 279	Continued From page 2 dated 6/10/14 noted "Psychosocial Well-being: Resident is at risk for impaired psychosocial well-being due to adjustment to the long-term care unit environment and new physical limitations due to current medical conditions, as evidenced by resident participation in long-term care protocols" Generalized non-pharmacological interventions included "1. Use a calm, reassuring approach. 2. Listen to and validate Residents' feelings. 3. Provide reassurance and comfort. 4. Offer prayer/spiritual support. 5. Offer one to one visits PRN.", "Offer one to one visits PRN. Listen to and validate Resident's feelings." and "Encourage use of relaxation techniques and involvement in activities. Encourage family participation" However, no intervention listed provided individualized interventions to decrease anxiety and insomnia for R69, for example what relaxation techniques may be most effective for R69 or what one to one visit activities may be most effective to decrease anxiety and promote sleep. Review of the resident record including current physician orders, medication and treatment administration histories for 7/15/14 through 8/13/14, sleep logs for July and August, NA/R [nursing assistant] flow sheets for August, 7/18/14 provider progress notes and July and August interdisciplinary team resident progress notes revealed no attempt was made to provide non pharmacological interventions to promote sleep or provide education to R69 on non pharmacological interventions to promote sleep. The NA/R flow sheet for July was requested on 8/14/14 at 9:00 a.m. but not provided by the facility. During interview on 8/14/14 at 8:48 a.m.	F 279	detected irregularities to Director of Nursing for follow-up. The Director of Nursing or designee is responsible to ensure this requirement is met.	

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F 279	Continued From page 3 ,Registerd Nurse (RN)-A, reviewed R69's medical record and confirmed non-pharmacological interventions have not been established for sleep and anxiety. RN-A reported non-pharmacological interventions for anxiety and insomnia should be charted in the progress notes. On 8/14/14 at 10:23 p.m., the director of nursing reported non-pharmacological interventions to promote sleep and decrease anxiety should have been offered to R69 and documented.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a temporary care plan, with interventions based on the resident's care needs at the time of admission, for 1 of 1 resident (R30) closed record reviewed for death. Findings include: Documentation review of R30's record indicated admission diagnosis of HTN (high blood pressure), GERD (gastric esophageal reflux disease), and dementia with behaviors. No care plan was included in R30's record. Interview with the Director of Nursing (DON) on 8/14/14 at 10:00 a.m., indicated that the expectation is for a temporary care plan to be completed on a resident during the first 24 hours of admission. The DON stated the Preadmission screening	F 281	Temporary care plans for new admissions and a policy was written and implemented on 8/1/14. A blank care plan and the policy was provided to the lead surveyor at the time of survey. All licensed nurses will be re-educated on implementation and updating of temporary care plans that are created upon admission. All temporary care plans will be monitored weekly during IDT meetings to ensure that they are correct and up to date. The Director of Nursing or designee is responsible to ensure this requirement is met.	9/12/14

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F 281	Continued From page 4 form had been used for the temporary care plan, and verified R30's Preadmission screening form lacked information regarding how much assistance R30 required with transfers, bed mobility, grooming, eating, and bathing. Review of the undated Care Plan Policy and Procedure received 8/14/14 at 10:20 a.m., indicated the following : It is the policy of this facility to provide a temporary care plan with 24 hours of admission (Admission Individual Care Plan).	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to follow the plan of care for activities of daily living (ADL's) for 1 of 3 residents (R39) reviewed for ADL's and for 1 of 5 residents (R57) reviewed for unnecessary medications. Findings include: R39's care plan for nail care was not followed. Review of the plan of care dated 6/10/14 directed staff that R39 required extensive assistance with personal hygiene and directed nursing to trim residents nails following the weekly bath. Observation on 8/12/14 at 1:15 p.m. revealed	F 282	Orders for routine nail care for R39 include during a regular activity each week and during the resident s bath time. New orders were added for resident R39 that instruct the charge nurse to inspect nails for R39 and clean as needed after routine nail care is provided and to document this in the electronic medical record. All staff will be re-educated regarding the importance of nail care, to check the nails each time the hands are washed and to report to the nurse when additional nail care is needed.	9/12/14

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F 282	Continued From page 5 R39 with long nails that were manicured and polished with a nude colored polish. Observation of the top and underside of the nails on the middle fingers and thumb revealed dark colored material under the nails. Cares were observed on 8/13/14 at 7:25 am with nursing assistant (NA)-A. NA-A washed R39's hands, face, and underarms with no special attention to the underside of the nails. Interview with the family (F)-A, on 8/12/14 at 11:44 a.m. revealed a concern that R39's nails always seem to be dirty with black debris under them. "They look bad." F-A indicated when she visits on the weekends she always ends up cleaning the nails. When interviewed on 8/14/14 at 1:50 p.m. the DON indicated there was no policy and procedure however the protocol is that nails are checked on bath day, cleaned and cut. The NA's, as part of their daily cares, should be checking the nails everyday and cleaning as needed. The nails should not be dirty and the family should not have to be responsible to clean them. R57's care plan for mood and behavior was not followed. R57's plan of care for mood and behavior dated 6/3/14, identified mood and behavior issues of mental and depressive disorder, insomnia and paranoia, with severely impaired decision making ability. The plan of care directed staff to monitor behaviors of agitation with delusion, combativeness with cares and directed staff to utilize 1 to 1, listen and validate feelings, discuss her past interests, offer choices, consistent routine, and explain and orient. The physicians orders revealed R57 was	F 282	For R57, individualized non pharmacological interventions have been added to the care plan, in addition to the general interventions that were already listed. A house audit will be completed for all residents with orders for PRN psychotherapeutic drugs to ensure that non pharmacological interventions are in place. The psychotropic medication policy has been revised to address non pharmacological interventions. Staff will be retrained on the appropriate place for documentation of non pharmacological interventions in the electronic medical record. All licensed nursing staff will be re-educated regarding the importance of identifying individualized non pharmacological interventions and attempting and documenting their effectiveness prior to administering PRN medications. The consultant pharmacist will include monitoring for irregularities with implementation of updated documentation protocol during monthly medication regimen reviews, and will report any detected irregularities to Director of Nursing for follow-up. Ongoing audits will be conducted to ensure that all residents with PRN	

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F 282	Continued From page 6 receiving Celexa (an antidepressant medication) 20 mg q a.m.(every am) for depression since 1/14/13; Seroquel (an antipsychotic medication) 25 mg three times a day (TID) (increased 6/26/14 to TID) and everyday (qd) as needed (prn). The regular dose of Seroquel had been started prior to 7/28/13 and the prn dose since 5/14/13. Ativan (an antianxiety medication) 0.5 mg qd prn since 3/2/14. The nurses notes were reviewed and identified the following behavioral concerns. 5/24/14 at 9:45 p.m. physically aggressive towards staff, Seroquel given. 5/25/14 at 7:45 p.m. physically aggressive, attempted to scratch staff. Ativan prn given at 7:30 p.m. 6/6/14 at 10:22 a.m. Ativan due to resident being combative with toileting and very upset. Crying and not easily redirected with 1:1. 6/25/14 at 1:13 p.m. very upset with getting bath... gave Ativan. Staff wanted increase in Ativan during bath. 6/26/14 at 1:00 p.m. the physician increased the Seroquel to TID, and discontinued the Ativan prior to shower. The physician also discontinued the shower and ordered bed bath only. 7/8/14 at 1:00 p.m. was combative with cares in the morning and Ativan was given. 7/22/14 at 8:30 p.m. was given prn Ativan for anxiety/depression and also Ultram for pain to the leg. 7/31/14 at 8:42 p.m. was given Ativan before cares. The notes revealed the resident was still resistive but did not yell at staff. 8/5/14 10:56 p.m. Ativan was given prior to bedtime (HS) cares to prevent lashing out and it was not effective. The resident refused to undress the top half but staff was able to do peri	F 282	psychotherapeutic medications have non pharmacological interventions in place and that documentation is complete. The Director of Nursing is responsible to ensure this requirement is met.	

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F 282	Continued From page 7 care. The nurses notes and medication administration record (MAR) lacked documentation that any of the nonpharmacological interventions were tried prior to the psychotherapeutic drug being given. When interviewed on 8/14/14 at 1:45 p.m. the DON stated non-pharmacological interventions should always be tried prior to medications being given and indicated the MAR had a comment section for that very reason but it appeared staff were not utilizing it. The policy and procedure (revised 5/14) for usage of Psychotropic medications was requested and when provided the usage of non-pharmacological interventions was not part of the procedure. The DON said that the usage of non-pharmacological interventions was a standard of nursing practice.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide the necessary care and services for activities of daily living (ADL's) for 1 of 3 residents (R39) observed receiving cares.	F 312	Orders for routine nail care for R39 include during a regular activity each week and during the resident s bath time. New orders were added for resident R39	9/12/14

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F 312	Continued From page 8	F 312		

Findings include:

R39 was observed during cares and did not receive nail care for soiled nails.

Observation of R39's nails 8/12/14 at 1:15 p.m. revealed long nails that were manicured and polished with a nude colored polish. Observation of the top and underside of the nails on the middle fingers and thumb revealed dark colored material under the nails.
Cares were observed on 8/13/14 at 7:25 a.m., with nursing assistant (NA)-A. NA-A washed R39's hands, face, and underarms with no special attention to the underside of the nails.

The significant change minimum data set (MDS) completed 5/29/14 indicated R39 was extensive assist with all personal cares. The care area assessment (CAA) summary dated 5/29/14 revealed the resident had declined in ability to perform ADL's and required extensive assistance of the staff.

The plan of care dated 6/10/14 indicated R39 needed extensive assistance with personal hygiene and directed nursing to trim residents nails following the weekly bath.

Interview with the NA-A after the morning cares on 8/13/14 at 7:45 a.m. revealed the resident was capable of doing some cares for herself such as washing hands and face. Most of the other cares she needed staff to do for her.

Interview with the family (F)-A, on 8/12/14 at 11:44 a.m. revealed a concern that R39's nails always seem to be dirty with black debris under

that instruct the charge nurse to inspect nails for R39 and clean as needed after routine nail care is provided and to document this in the electronic medical record.

All staff will be re-educated regarding the importance of nail care, to check the nails each time the hands are washed and to report to the nurse when additional nail care is needed.

The Director of Nursing or designee is responsible to ensure this requirement is met.

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F 312	Continued From page 9 them. "They look bad." F-A indicated when visiting on the weekends, always ends up cleaning the nails. When interviewed on 8/14/14 1:50 p.m. the DON indicated there was no policy and procedure specific to nail care, however, the protocol is that nails are all checked on bath day, cleaned and cut. The NA's, as part of their daily cares, should be checking the nails everyday and clean as needed. The nails should not be dirty and the family should not have to be responsible to clean them.	F 312		
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		9/12/14

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F 329	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to implement non-pharmacological interventions for 2 of 5 residents (R57, R69) reviewed for unnecessary medications. Findings include: R57's plan for the use of non-pharmacological interventions for mood and behavior issues was not implemented. Review of an annual minimum data set (MDS), completed 5/22/14, the mood and behavior section identified R57 as being short tempered, easily annoyed on 7-11 days and physical aggression 1-3 days. R57's plan of care for mood and behavior, dated 6/3/14, identified mental and depressive disorder, insomnia and paranoia, with severely impaired decision making ability. The plan of care directed staff to monitor behaviors of agitation with delusion, combativeness with cares and directed staff to utilize 1 to 1, listen and validate feelings, discuss past interests, offer choices, consistent routine, explain and orient. Review of physicians orders, identified R57 was receiving Celexa 20 mg every am (q a.m.) for depression since 1/14/13; Seroquel 25 mg three times a day (TID) (increased 6/26/14 to TID) and everyday (qd) as needed (prn). The regular dose	F 329	For R57 and R69, individualized non pharmacological interventions have been added to the care plan, in addition to the general interventions that were already listed. A house audit will be completed for all residents with orders for PRN psychotherapeutic drugs to ensure that non pharmacological interventions are in place. The psychotropic medication policy has been revised to address non pharmacological interventions. Staff will be retrained on the appropriate place for documentation of non pharmacological interventions in the electronic medical record. All licensed nursing staff will be re-educated regarding the importance of identifying individualized non pharmacological interventions and attempting and documenting their effectiveness prior to administering PRN medications. The consultant pharmacist will include monitoring for irregularities with implementation of updated documentation protocol during monthly medication	

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F 329	Continued From page 11 of Seroquel had been started prior to 7/28/13 and the prn dose since 5/14/13. Ativan 0.5 mg qd prn since 3/2/14. The nurses notes were reviewed and identified the following behavioral concerns. 5/24/14 at 9:45 p.m. physically aggressive towards staff with Seroquel given. 5/25/14 at 7:45 p.m. physically aggressive and attempted to scratch staff. Ativan prn given at 7:30 p.m. 6/6/14 at 10:22 a.m. Ativan given due to resident being combative with toileting and very upset. Resident was crying and not easily redirected with 1:1. 6/25/14 at 1:13 p.m. very upset with getting bath... Ativan given. Staff wanted an increase in the Ativan during the bath. 6/26/14 at 1:00 p.m. the physician increased the Seroquel to TID, and discontinued the Ativan prior to shower. The physician also discontinued the shower and ordered bed bath only. 7/8/14 at 1:00 p.m. was combative with cares in the morning and Ativan was given. 7/22/14 at 8:30 p.m. was given prn Ativan for anxiety/depression and also Ultram for pain to leg. 7/31/14 at 8:42 p.m. was given Ativan before cares. The notes revealed the resident was still resistive but did not yell at staff. 8/5/14 10:56 p.m. Ativan was given prior to bedtime (HS) cares to prevent lashing out and it was not effective. The resident refused to undress the top half but staff was able to do peri care. The nurses notes and medication administration record (MAR) did not address if any non-pharmacological interventions were tried prior to the psychotherapeutic drug being given.	F 329	regimen reviews, and will report any detected irregularities to Director of Nursing for follow-up. Ongoing audits will be conducted to ensure that all residents with PRN psychotherapeutic medications have non pharmacological interventions in place and that documentation is complete. The Director of Nursing or designee is responsible to ensure this requirement is met.	

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	245254	A. BUILDING ____ B. WING ____	08/14/2014

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F 329	Continued From page 12 When interviewed on 8/14/14 at 1:45 p.m. the DON stated nonpharmacological interventions should always be tried prior to medications being given and indicated the MAR had a comment section for that very reason, but it appears staff are not utilizing it. The policy and procedure (revised 5/14) for usage of Psychotropic medications was requested and when provided the usage of non-pharmacological interventions was not part of the procedure. The DON said that the usage of non-pharmacological interventions is a standard of nursing practice. The facility failed to ensure non- pharmacological interventions were provided to potentially reduce the use of anti-anxiety medications administered to reduce anxiety and promote sleep at night for R69. Review of R69's admission Minimum Data Set [MDS], dated 5/15/14 revealed R69 was cognitively intact. Review of R69's Physician Order Report, dated 7/14/14 through 8/14/14 revealed orders for scheduled lorazepam 0.25 milligrams (mg) each night for increased anxiety and insomnia. An as needed (prn) lorazepam 0.25 mg was available for insomnia if the scheduled dose was not effective. (Lorazepam is an anti-anxiety medication.) Review of the Medication Administration History for 7/15/14 through 8/13/14 revealed the as needed dose of lorazepam was administered to R69 eight times due to complaints of insomnia.	F 329		

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F 329	Continued From page 13	F 329		

Review of R69's care area assessment, dated 6/9/14, revealed "Res [resident] is on antianxiety and antidepressant as ordered. Dx [diagnoses] depression, anxiety. Staff to monitor for changes, s/e [side effects] effectiveness. Call light w/n [within] reach, proceed to cp [care plan]"

Review of R69's care plan revealed a Mood/Behavior section, dated 6/10/14, which noted "Mood/behavior: May be related to: Diagnosis of hearing loss, memory loss, sleep disturbance and depressive disorder, as evidenced by: PHQ-9 (depression screening tool) of 12/27, indicating possible moderate level of depression." A Psychosocial Well-Being section, dated 6/10/14 noted "Psychosocial Well-being: Resident is at risk for impaired psychosocial well-being due to adjustment to the long-term care unit environment and new physical limitations due to current medical conditions, as evidenced by resident participation in long-term care protocols" Generalized non-pharmacological interventions included "1. Use a calm, reassuring approach. 2. Listen to and validate Residents' feelings. 3. Provide reassurance and comfort. 4. Offer prayer/spiritual support. 5. Offer one to one visits PRN.", "Offer one to one visits PRN. Listen to and validate Resident's feelings." and "Encourage use of relaxation techniques and involvement in activities. Encourage family participation" However, no intervention listed provided individualized interventions to decrease anxiety and insomnia for R69, for example what relaxation techniques may be most effective for R69 or what one to one visit activities may be most effective to decrease anxiety and promote sleep.

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F 329	Continued From page 14 Review of the resident record including current physician orders, medication and treatment administration histories for 7/15/14 through 8/13/14, sleep logs for July and August, NA/R [nursing assistant] flow sheets for August, 7/18/14 provider progress notes and July and August interdisciplinary team resident progress notes revealed no attempt was made to provide non-pharmacological interventions to promote sleep or provide education to R69 on non-pharmacological interventions to promote sleep. The NA/R flow sheet for July was requested on 8/14/14 at 9:00 a.m. but not provided by the facility. During interview on 8/14/14 at 8:48 a.m., registered nurse (RN)-A, reviewed medical record and confirmed non-pharmacological interventions had not been established for sleep and anxiety. RN-A reported non-pharmacological interventions for anxiety and insomnia should be charted in the progress notes. On 8/14/14 at 10:23 p.m., the director of nursing reported non-pharmacological interventions to promote sleep and decrease anxiety should have been offered to R69 and documented.	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:	F 356		9/12/14

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F 356	Continued From page 15 - 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 by: Based on observation, interview and document review, the facility failed to ensure the nurse staff posting included actual hours worked and used terminology understandable to general public for 7 of 7 postings reviewed and failed to ensure it was posted for the current date for 1 of 1 observation. This had the potential to no more than minimally impact all residents, visitors and staff who may wish to view the posted staffing hours. Findings include: On 8/11/14 at 1:30 p.m. the Report of Nursing	F 356	The nurse staff posting template was immediately revised to show numbers of staff by shift times instead of by day, evening and night and instructions were added to the template. The term FTE was replaced with Number of Staff. Staff will be reminded to verify that the correct day, date and numbers are on the daily form. The Director of Nursing or designee is responsible to ensure this requirement is met.	

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F 356	Continued From page 16 Staff Directly Responsible For Resident Care was observed posted near the entrance of the nursing home. The posting was dated 8/10/14, the previous date. The posting did not indicate the actual hours (e.g.. 6 a.m. to 2:30 p.m.) worked by nursing staff in each category of licensed and unlicensed nursing staff. The posting listed Shifts: Day, Evening and Night, FTEs and total hours for registered nursing staff, licensed nursing staff, nursing assistants and trained medication assistants. The posting did not explain the definition of the abbreviation "FTE" The staffing coordinator, present for the observation, confirmed the posting did not include the actual hours worked, or explain what FTE meant. Review of Report of Nursing Staff Directly Responsible For Resident Care for 8/4/14 through 8/10/14 revealed nursing hours listed in the same manner as the 8/11/14, with no explanation of the term "FTE" and no actual hours posted.	F 356		
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. This REQUIREMENT is not met as evidenced	F 428		9/12/14

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F 428

Continued From page 17

by:
Based on document review and interview, the consultant pharmacist failed to advise the facility to utilize non-pharmacological interventions for mood and behaviors, prior to medication use for 1 of 5 resident (R57) reviewed for unnecessary medications, and the facility failed to follow consultant pharmacist recommendations regarding ensuring non-pharmacological interventions were provided for 1 of 5 residents (R69) to reduce anxiety and promote sleep at night.

The consultant pharmacist failed to advise the facility to utilize non-pharmacological interventions prior to the use of as needed (PRN) psychotherapeutic medications.

Findings include:

Review of an annual minimum data set (MDS), completed 5/22/14, the mood and behavior section revealed R57 was identified as being short tempered, easily annoyed on 7-11 days and physical aggression 1-3 days.

R57's plan of care for mood and behavior dated 6/3/14, identified mood and behavior issues of mental and depressive disorder, insomnia and paranoia, with severely impaired decision making ability. The plan of care directed staff to monitor behaviors of agitation with delusion, combativeness with cares and directed staff to utilize 1 to 1, listen and validate feelings, discuss past interests, offer choices, consistent routine, explain and orient.

Review of physicians orders, identified R57 was receiving Celexa 20 mg every am (q a.m.) for

F 428

For R57 and R69, individualized non pharmacological interventions have been added to the care plan, in addition to the general interventions that were already listed.

The senior consulting pharmacist assured Regina that this issue was discussed with the consultant pharmacist identified.

Facility will notify consultant pharmacist of updated protocol for documenting use of non pharmacological interventions in electronic health record.

A house audit will be completed for all residents with orders for PRN psychotherapeutic drugs to ensure that non pharmacological interventions are in place.

All licensed nursing staff will be re-educated regarding the importance of identifying individualized non pharmacological interventions and attempting and documenting their effectiveness prior to administering PRN medications.

The consultant pharmacist will include monitoring for irregularities with implementation of updated documentation protocol during monthly medication regimen reviews, and will report any detected irregularities to Director of Nursing for follow-up.

Residents with orders for PRN

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	245254	A. BUILDING ______ B. WING ______	08/14/2014

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F 428	Continued From page 18 depression since 1/14/13; Seroquel 25 mg three times a day (TID) (increased 6/26/14 to TID) and everyday (qd) as needed (prn). The regular dose of Seroquel had been started prior to 7/28/13 and the prn dose since 5/14/13. Ativan 0.5 mg qd prn since 3/2/14. The nurses notes were reviewed and identified the following behavioral concerns. 5/24/14 at 9:45 p.m. physically aggressive towards staff with Seroquel given. 5/25/14 at 7:45 p.m. physically aggressive and attempted to scratch staff. Ativan prn given at 7:30 p.m. 6/6/14 at 10:22 a.m. Ativan given due to resident being combative with toileting and very upset. Resident was crying and not easily redirected with 1:1. 6/25/14 at 1:13 p.m. very upset with getting bath... Ativan given. Staff wanted an increase in the Ativan during the bath. 6/26/14 at 1:00 p.m. the physician increased the Seroquel to TID, and discontinued the Ativan prior to shower. The physician also discontinued the shower and ordered bed bath only. 7/8/14 at 1:00 p.m. was combative with cares in the morning and Ativan was given. 7/22/14 at 8:30 p.m. was given prn Ativan for anxiety/depression and also Ultram for pain to leg. 7/31/14 at 8:42 p.m. was given Ativan before cares. The notes revealed the resident was still resistive but did not yell at staff. 8/5/14 10:56 p.m. Ativan was given prior to bedtime (HS) cares to prevent lashing out and it was not effective. The resident refused to undress the top half but staff was able to do peri care. The nurses notes and medication administration	F 428	psychotherapeutic drugs are discussed on a regular basis with the pharmacist during MED meetings. The Director of Nursing or designee is responsible to ensure this requirement is met.	

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F 428	Continued From page 19	F 428		

record (MAR) did not indicate any of the nonpharmacological interventions were attempted prior to the psychotherapeutic drug being given.

The pharmacy notes reviewed for 5/31/14 and 6/26/14 indicated medication regimen reviewed and no irregularities. The pharmacy notes dated 7/9/14 indicated slight improvement in behaviors with increased Seroquel although continues to be paranoid and combative with cares. The pharmacist did not address the lack of nonpharmacological interventions.

When interviewed on 8/14/14 at 1:45 p.m. the DON indicated nonpharmacological interventions should always be tried prior to medications being given and stated the MAR had a comment section for that very reason but it appears that staff are not utilizing it.

The policy and procedure (revised 5/14) for usage of Psychotropic medications was requested and when provided the usage of non-pharmacological interventions was not part of the procedure. The DON said that non pharmacological interventions would be a standard of nursing practice.

When interviewed on 8/14/14 at 3:15 p.m. the consulting pharmacist (CP)-B indicated she was new to this facility and did not fully know all the residents and their medications. She would assume the staff was using nonpharmacological interventions prior to the usage of the PRN psychotherapeutic medications as identified in the plan of care, however, had not specifically addressed that particular issue.

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F 428	Continued From page 20 The facility failed to follow consultant pharmacist recommendations regarding ensuring non-pharmacological interventions were provided to assist R69 to reduce anxiety and promote sleep at night. Review of R69's admission Minimum Data Set [MDS], dated 5/15/14 revealed R69 was cognitively intact. Review of R69's Physician Order Report, dated 7/14/14 through 8/14/14 revealed orders for scheduled lorazepam 0.25 milligrams (mg) each night for increased anxiety and insomnia. An as needed (prn) lorazepam 0.25 mg was available for insomnia if the scheduled dose was not effective. (Lorazepam is an anti-anxiety medication.) Review of the Medication Administration History for 7/15/14 through 8/13/14 revealed the as needed dose of lorazepam was administered to R69 eight times due to complaints of insomnia. Review of R69's care area assessment, dated 6/9/14, revealed "Res [resident] is on antianxiety and antidepressant as ordered. Dx [diagnoses] depression, anxiety. Staff to monitor for changes, s/e [side effects] effectiveness. Call light w/n [within] reach, proceed to cp [care plan]" Review of R69's care plan revealed a Mood/Behavior section, dated 6/10/14, which noted "Mood/behavior: May be related to: Diagnosis of hearing loss, memory loss, sleep disturbance and depressive disorder, as evidenced by: PHQ-9 (depression screening tool) of 12/27, indicating possible moderate level of depression." A Psychosocial Well-Being section,	F 428		

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F 428	Continued From page 21 dated 6/10/14 noted "Psychosocial Well-being: Resident is at risk for impaired psychosocial well-being due to adjustment to the long-term care unit environment and new physical limitations due to current medical conditions, as evidenced by resident participation in long-term care protocols" Generalized non-pharmacological interventions included "1. Use a calm, reassuring approach. 2. Listen to and validate Residents' feelings. 3. Provide reassurance and comfort. 4. Offer prayer/spiritual support. 5. Offer one to one visits PRN.", "Offer one to one visits PRN. Listen to and validate Resident's feelings." and "Encourage use of relaxation techniques and involvement in activities. Encourage family participation" However, no intervention listed provided individualized interventions to decrease anxiety and insomnia for R69, for example what relaxation techniques may be most effective for R69 or what one to one visit activities may be most effective to decrease anxiety and promote sleep. Review of the resident record including current physician orders, medication and treatment administration histories for 7/15/14 through 8/13/14, sleep logs for July and August, NA/R [nursing assistant] flow sheets for August, 7/18/14 provider progress notes and July and August interdisciplinary team resident progress notes revealed no attempt was made to provide non pharmacological interventions to promote sleep or provide education to R69 on non pharmacological interventions to promote sleep. The NA/R flow sheet for July was requested on 8/14/14 at 9:00 a.m. but not provided by the facility. A Consultant Pharmacy Communication to	F 428		

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F 428	Continued From page 22 Nursing, dated 5/31/14, noted "[R69] has an order for 0.25 mg lorazepam every bedtime, with repeat dose available x 1 before 0300 if awake. The eMAR [electronic medication administration record] shows the daily bedtime dose given at an unspecified time, with the repeat dose being given frequently between 2200 and 2300. Nursing notes do not describe non-drug interventions being used to help promote comfort and sleep. To perhaps, reduce need for additional PRN dosing, would suggest trial of changing scheduled dose of bedtime lorazepam to be given at 2200." The note was from a consultant pharmacist (CP)-A, who had previously consulted for the facility. The response from nursing, dated 6/3/14, noted "Scheduled dose changed to 2200 daily." with no response regarding non drug interventions for sleep. During interview on 8/14/14 at 8:48 a.m. a nursing supervisor, (RN)-A, reviewed medical record and confirmed non-pharmacological interventions have not been established for sleep and anxiety. RN-A reported non-pharmacological interventions for anxiety and insomnia should be charted in the progress notes. On 8/14/14 at 10:23 p.m., the director of nursing reported non pharmacological interventions to promote sleep and decrease anxiety should have been offered to R69 and documented. During phone call interview on 8/14/14 at 2:56 p.m. the current consultant pharmacist (CP)-B reported she would review the care plan to see what non-pharmacological interventions were being used for sleep. CP-B reviewed the care plan and read to surveyor the general, non resident specific non-pharmacological	F 428		

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F 428	Continued From page 23 interventions noted, such as using a calm approach. CP-B noted non-pharmacological sleep hygiene interventions should be in place. However, she would not expect them to necessarily be re-done prior to each as needed dose.	F 428		

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

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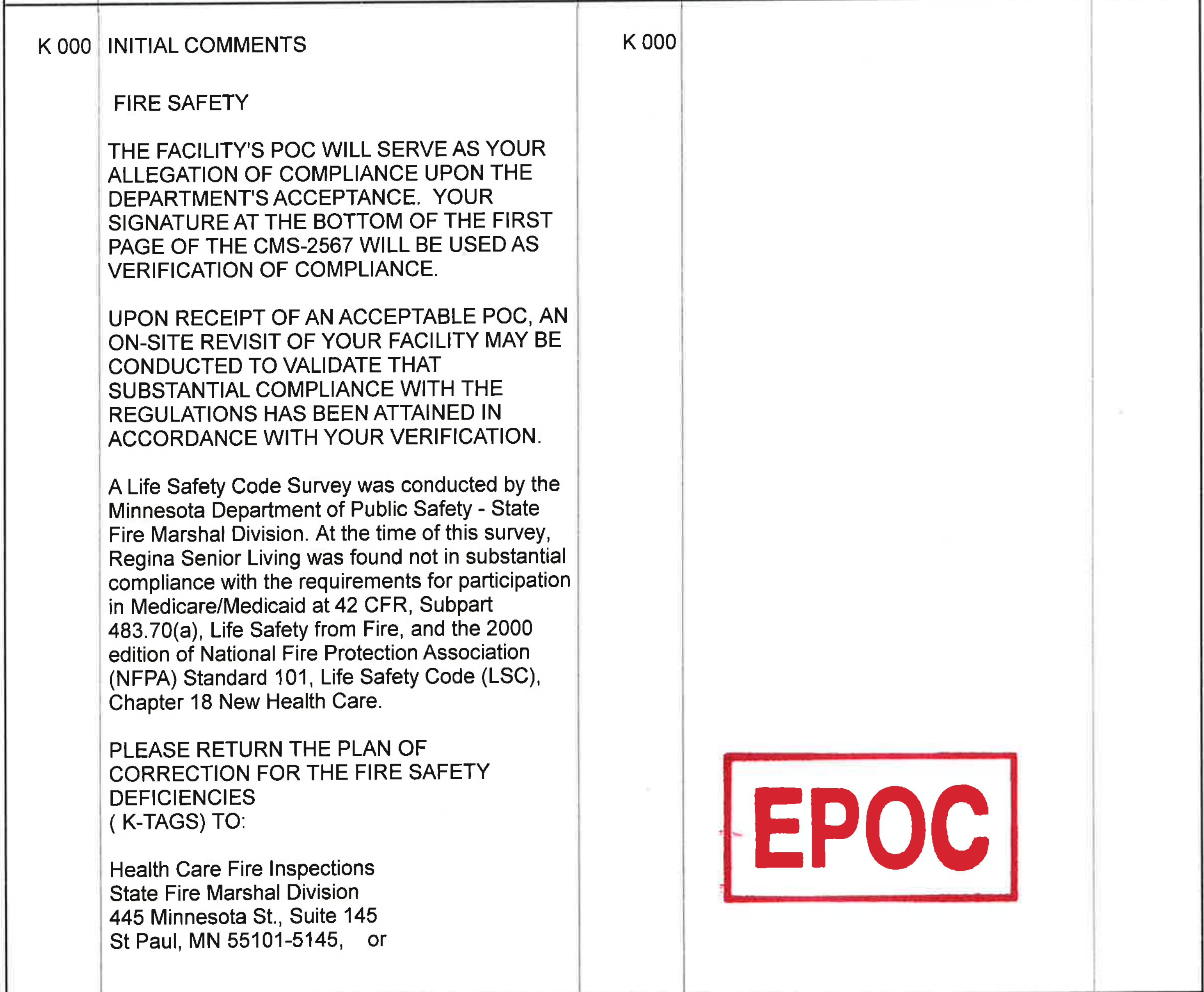
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	**1175 NININGER ROAD HASTINGS, MN 55033**



(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 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 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Regina Senior Living 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 18 New 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 St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/05/2014

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
	245254	A. BUILDING **02 - 2012 ADDITION BLDG** B. WING _______	**08/12/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	**1175 NININGER ROAD** **HASTINGS, MN 55033**

(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 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as two separate buildings. The 2012 addition is a 1-story building, with no basement and was determined to be of Type II(111) construction. The facility is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridor and resident sleep rooms that is monitored for automatic fire department notification. The facility has a capacity of 61 beds and had a census of 60 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware	K 050		8/20/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING **02 - 2012 ADDITION BLDG** B. WING	**08/12/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	**1175 NININGER ROAD** **HASTINGS, MN 55033**

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K 050	Continued From page 2 that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 60 residents. Findings include: On facility tour between 10:30 AM and 1:00 PM on 08/12/2014, the review of the fire drill documentation for the past 12 months (August 2013 to July 2014) revealed the drills for the following shifts were completed but did not sufficiently vary the times that the drills were conducted: Day: 0750, 1022, 1026 and 0844 hours Evening: 2130,2020, 2105 and 1800 hours This deficient practice was confirmed by the Director of Environmental Services (JB) at the time of discovery. *TEAM COMPOSITION*	K 050	Regina Senior Living (RSL) has instructed the Regina Hospital Plant Operations staff conducting the drills on RSL's behalf to assure that fire drills are held at varying times at least quarterly on each shift. Report of fire drill date and times will be sent regularly to RSL's Environmental Services Director for review of ongoing compliance. The Environmental Services Director or designee is responsible to assure compliance with this Life Safety Code Standard.	

PRINTED: 09/10/2014
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
	245254	A. BUILDING **02 - 2012 ADDITION BLDG** B. WING	**08/12/2014**

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K 050	Continued From page 3 Gary Schroeder, Life Safety Code Spc.	K 050		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING 01 - **NURSING HOME** B. WING	**08/12/2014**

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 09/05/2014

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

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	245254	A. BUILDING **01 - NURSING HOME** B. WING ______	**08/12/2014**

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as two separate buildings. Regina Senior Living is a 1-story building, with a full basement. The facility was built in 1965 and was determined to be of Type II(111) construction. This facility will be surveyed as two separate buildings. The facility is fully sprinklered, with heads in the closets of all resident sleeping rooms. The facility is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridor and resident sleep rooms that is monitored for automatic fire department notification. The facility has a capacity of 61 beds and had a census of 60 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		8/20/14

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	245254	A. BUILDING **01 - NURSING HOME** B. WING ______	**08/12/2014**

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K 050 SS=D	Continued From page 2 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 60 residents. Findings include: On facility tour between 10:30 AM and 1:00 PM on 08/12/2014, the review of the fire drill documentation for the past 12 months (August 2013 to July 2014) revealed the drills for the following shifts were completed but did not sufficiently vary the times that the drills were conducted: Day: 0750, 1022, 1026 and 0844 hours Evening: 2130,2020, 2105 and 1800 hours This deficient practice was confirmed by the Director of Environmental Services (JB) at the	K 050	Regina Senior Living (RSL) has instructed the Regina Hospital Plant Operations staff conducting the drills on RSL's behalf to assure that fire drills are held at varying times at least quarterly on each shift. Report of fire drill date and times will be sent regularly to RSL's Environmental Services Director for review of ongoing compliance. The Environmental Services Director or designee is responsible to assure compliance with this Life Safety Code Standard.	

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K 050	Continued From page 3 time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 050		