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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: G2RV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00407

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/18/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **50** (L18)
13.Total Certified Beds **50** (L17)

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Unit Supervisor 10/20/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 12/12/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/27/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245395

December 12, 2016

Mr. Scott Buchanan, Administrator
Crossroads Care Center
965 McMillan Street
Worthington, Minnesota 56187

Dear Mr. Buchanan:

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 October 11, 2016 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 20, 2016

Mr. Scott Buchanan, Administrator
Crossroads Care Center
965 McMillan Street
Worthington, Minnesota 56187

RE: Project Number S5295026

Dear Mr. Buchanan:

On September 19, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 1, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On October 18, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 14, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 1, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 11, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 1, 2016, effective October 11, 2016 and therefore remedies outlined in our letter to you dated September 19, 2016, 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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245395 Y1	A. Building B. Wing Y2	10/18/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0244	Correction	ID Prefix F0334	Correction	ID Prefix F0431	Correction
Reg. # 483.15(c)(6)	Completed	Reg. # 483.25(n)	Completed	Reg. # 483.60(b), (d), (e)	Completed
LSC	10/11/2016	LSC	10/11/2016	LSC	10/11/2016
ID Prefix F0441	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.65	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/11/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	GL/mm	10/20/2016	15507	10/18/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
9/1/2016

☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245395	A. Building 01 - MAIN BUILDING 01 B. Wing	10/14/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 10/11/2016	ID Prefix Reg. # NFPA 101 LSC K0048	Correction Completed 10/11/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	TL/mm	10/20/2016	35482	10/14/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
8/30/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: G2RV

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/01/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

13.Total Certified Beds **50** (L17)

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Jane Teipel, HFE NEII — 10/18/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 10/19/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 19, 2016

Mr. Scott Buchanan, Administrator
Crossroads Care Center
965 McMillan Street
Worthington, Minnesota 56187

RE: Project Number S5395026

Dear Mr.. Buchanan:

On September 1, 2016, 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:

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794 Fax: (651) 215-9697

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 October 11, 2016, 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 December 1, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 1, 2017 (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
Health Regulation Division
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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING _____ B. WING _____	09/01/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to document and act upon concerns voiced by residents during resident council meetings regarding food and call lights, potentially affecting most of the 36 residents residing in the facility. Findings include: Resident Council Meeting Agenda and Minutes from 5/5/16, to 8/1/16, were reviewed. The	F 244	1. Residents 31, 48, 52, and 38 expressed to surveyors concerns about food. Administrator followed up with residents by 10/11/16 and discussed food concerns and explained new resident council process to ensure concerns from resident council are appropriately followed up on. Residents 31, 38, and 7 expressed concerns to surveyors about call light response times. Administrator followed up with residents by 10/11/16 and discussed	10/11/16

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

Electronically Signed | 09/28/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING _____ B. WING _____	09/01/2016

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

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F 244	Continued From page 1 minutes included Old Business, Administration, Maintenance, Dietary, Nursing, Housekeeping/Laundry, Activities, Social Services and Employee of the Month. Although residents brought forward concerns for the various department staff, the minutes did not reflect the facility's actual resolution to residents' concerns. Instead, each month's minutes reflected "Old Business: Reviewed." The minutes indicated the dietary manager would follow up to food concerns and the director of nursing would follow up on call light concerns, but did not indicate whether residents were satisfied with the solutions and/or considered the problems resolved. 1) May 2016, Residents asked that a description of the food being served be available. 2) June 2016, "Menus need to be clearer." Pork chops and fish were hard and residents would like more crunchy veggies such as carrots and celery. One resident requested fewer mashed potatoes and more other vegetables. Broccoli was white not green. It had been cooked too long. 3) July 2016 Meats were over cooked, baked potatoes were burnt, broccoli and cauliflower were overcooked. In addition, "Call light response has been slow." 4) August 2016 Sausage ends were too hard, cauliflower continued to be mushy at times. "Call lights in the afternoon and morning continue to be slower with responses." During a dining observation on 8/30/16, at 12:09 p.m. six residents on second floor had trays delivered to their rooms. At 12:14 p.m. R31	F 244	call light concerns and explained new resident council process to ensure concerns from resident council are appropriately followed up on. Administrator will review resident council minutes for last 6 months and address any resident concerns that may have been omitted and document what actions were taken including food and call light concerns by 10/11/16. 2. All residents have the potential to be affected. 3. Department Managers were trained on 9/19/16 regarding the new program for managing old/new business and resident concerns for resident council. Dietary staff will be educated by 10/11/16 regarding proper food textures and presentation. Education will be provided to nurses by 10/11/16 regarding responsibility to monitor the timely answering of call lights, acceptable call light response times, and managing staff to help reduce response times. Starting at the resident council meeting on 9/12/16, the resident council minutes were changed to reflect old business and new business. All old business concerns are to be discussed at resident council and actions taken by staff to resolve the concern will be shared. After discussion, residents will vote whether they are satisfied or dissatisfied regarding the concern being resolved. If there are no dissatisfied votes, the concern will be considered to be resolved. If there are dissatisfied votes, the concern will remain old business. New business	

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F 244	Continued From page 2 explained that staff will first passed out the drinks then returned later with the tray of food. R31 stated, "When the food does come up it's usually only lukewarm warm. I have had to ask them to microwave it, but when there is bread on the tray it doesn't taste good." The same day at 12:29 p.m. the meal trays arrived on the floor and was passed by two nursing assistants (NAs). Four of the six residents reported their meal was lukewarm, and stated most meals were not served hot. On 8/31/16, at 8:14 a.m. the DM stated she attended all of the resident council meetings, but had only heard of food concerns "a couple of times." The DM explained if the residents said they did not like something, then it was changed. The DM stated, "I haven't heard of any concerns for the last 2-3 months." If the DM could not attend a meeting, she obtained the minutes from the SSD and was informed which residents expressed specific concerns. The DM did not document resolutions to the residents' concerns. The DM explained that the food was taken from the steam tables in the kitchen, placed on a warm plate, covered with a thermal cover, and the plate placed on a tray and inside an unheated open-sided cart. The nursing staff was then overhead paged that the cart was being sent up on the elevator. On 8/31/16, the DM and surveyor observed meal trays being passed on the 2nd floor. The meal tray was sent up in the elevator at 8:29 a.m. and the last tray was delivered to R31 at 8:38 a.m. The DM measured the temperature and stated the eggs and sausage were 110 degrees, but should have been closer to 140 degrees to be palatable. R31 stated, "Well, the staff can't bring	F 244	will also be discussed at resident council to allow residents to voice any new concerns they may have. Once a concern is identified, a Resident Council Follow Up Form will be started by the Social Worker or designee and given to the department responsible for taking action to fix the concern. The form will be brought to the following resident council meeting for discussion on actions taken to resolve the concern. This same process will occur for old business that has not been resolved per resident vote. 4. Audits of resident council concerns will be completed monthly for 3 months by the administrator or designee to ensure appropriate actions are taken and appropriate follow up is completed for all resident council concerns from each resident council meeting starting with concerns voiced at resident council meeting on 9/12/16. Audits will verify resident council follow up form is completed appropriately, concern is investigated, actions taken, and improvement shown prior to the following resident council meeting. Audit results will be reported to the Quality Assurance Committee for review at the next Quality Assurance meeting.	

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F 244	Continued From page 3	F 244		

me hot food--they have a lot of trays to pass." The DM stated food should be served hot and to the residents' liking. At 8:46 a.m. the DM and surveyor asked R48 and R52 who also received room trays about the temperature of the food. Both residents reported the food was usually only lukewarm and never was served hot. R52 added that the toast that day was "just too hard to eat" and vegetables were often undercooked, including a few days prior his baked potato was not cooked through.

R52 stated on 8/30/16, at 10:18 a.m. that, "Sometimes the vegetables are hard and too hard to digest like broccoli and potatoes." R52 reported he also sometimes did not like both the main entree or the alternative that was offered.

R31 stated on 8/30/16, at 10:31 a.m. "The food here needs improvement...the presentation is awful," and looked like it should not have been eaten, so she did not then eat it. R31 said she did not think the cooks tasted the food, as no seasoning was added. R31 stated there was no fresh vegetables and the "broccoli last night was disgusting in color and texture" and stated she did not eat it. R31 stated the sweet potatoes looked like they had just been plopped out of the can onto her plate with hunks and juice. R31 stated she had made complaints to the dietary staff. creamy tuna bake was runny and very bland, and condiments were never offered. The R31 stated an alternative was offered, but some did not taste good. R38 stated "Sometimes they know how to scramble eggs and sometimes they do not." R31's admission Minimum Data Set (MDS) dated 7/29/16, indicated her cognition was intact.

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R38 was interviewed on 8/30/16, at 11:52 a.m. and stated, "The food is terrible here." She did not like the soups and said grilled cheese sandwiches were served too often. R38 stated she had asked for cottage cheese but did not receive it. R38 also stated, "The hamburger is awful and cooked very thin...The broccoli and asparagus are overcooked until white and watery...I think the food is awful here." R38 reported that staff did offer something else, but there was "not too much to pick from." R38 stated the bread was" the worst--so moist and limp-- the toast just keeps stretching and stretching." R38 stated she had complained about the bread at every resident council meeting, but the residents continued to be served the same bread for 18 months. R38 stated the chicken breast was always tough and dry, and stated "I think it is the products they use." R38 also reported the ice cream cups were "always melting" and she heard it was because that they had to get them from the other side of the building. R38's annual MDS dated 8/5/16, indicated her cognition was intact.

On 8/29/16, at 6:19 p.m. the DM explained residents helped choose the menu and discussed food concerns at resident council meetings and at food committee meetings every other week. On 8/31/16, at 1:44 p.m. the DM stated she met with residents once monthly to discuss food, and had tried to find a "happy medium" since some residents likes vegetables cooked less than others. The DM stated she attended the monthly resident council minutes, and heard food issued and tried to make changes.

On 8/31/16, at 11:21 a.m. the administrator stated very few concern forms had been received in the previous year, and no concern forms regarding

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food had been received. The administrator explained that the residents were aware they could go to management with their concerns, and that various managers attended the resident council meetings.

R31 reported on 8/30/16, at 10:28 a.m. "No" she did not think there was enough staff available at the facility without her waiting a long time for her cares and needs to be met. R31 stated she thought there should have been an additional staff person in the mornings when it was time to get up, at meal times, and in the evenings at bedtime. R31 stated she had to wait to go to bed, and 15-20 minutes to use to the bathroom, as the facility was "short staffed here." R31 was told she had to wait while a staff person located a second staff to assist because she was usually transferred with two people, but that day she had been transferred with just one staff. R31's admission MDS dated 7/29/16, indicated her cognition was intact.

R38 also reported on 8/30/16, at 11:41 a.m. "No" she did not think there was enough staff available at the facility without her waiting a long time for her cares and needs to be met. R38 stated she had to wait long around meal time, later in the morning later in the afternoon and had to wait 10-15 minutes to go to the bathroom and as long as 20 minutes. R38 stated she was on "water pills" and "when I have to go I have to go." R38's annual MDS dated 8/5/16, indicated her cognition was intact.

R7 was interviewed about resident council on 8/30/16, at 4:52 p.m. and stated some of the residents had expressed concerns about slower

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call lights in the mornings and afternoons. The staff had responded that residents just needed to put on their call lights and they should expect a response in 10 minutes. R7 further stated the DON was supposed to follow up to the concern, but R7 was unsure whether this had been done.

On 8/30/16, at 5:11 p.m. the social service director (SSD) was interviewed regarding resident council. The SSD stated the administrator, DON, dietary and maintenance all attended resident council meetings. If there was a resident concern it was addressed immediately if possible and if not, the staff would followed up. The SSD stated "At resident council meetings we ask if residents see improvement and if the problem was fixed. There is not a written follow up to any resident concerns from the meetings, but we discuss old business at the meetings. There really is not a way to see what residents concerns we are addressing or followed up on as it is not written anywhere."

On 8/31/16, at 9:05 a.m. the administrator was interviewed regarding resident council. The administrator stated the SSD was in charge of resident council and brought concerns to various department heads. The administrator stated "We do not have the best process of documenting what was done to rectify the situation. We have not done a good job documenting when there are issues and how we are going to follow up with the resident." The administrator stated he would have expected food to be delivered at the proper temperature call lights to be answered timely. The administrator added, "We can do a better job of documenting what we are doing to follow up on resident concerns raised at resident council meetings and how we document resolutions."

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F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has	F 334		10/11/16

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F 334	Continued From page 8 already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure vaccinations were offered per the Centers for Disease Control (CDC) recommendations for 5 of 5 residents (R26, R40, R14, R7, R33) whose immunization records were reviewed. In addition, the facility failed to develop guidelines that included Pneumococcal Conjugate Vaccine (PCV)-13 consistent with current CDC recommendations. Findings include:	F 334	1. The facility has developed a new policy regarding pneumococcal vaccinations. Residents 26, 40, 14, 7, and 33 were educated regarding the PCV-13 and PCV-23 pneumococcal vaccine, and offered the vaccines as appropriate by 10/11/16. 2. All residents have the potential to be affected and all resident's records were reviewed to ensure pneumococcal	

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F 334	Continued From page 9 R26 was 69 years old, and had been admitted to the facility in 1/16. Immunization and medical records revealed the resident had not been informed of, was offered, nor had received either the PCV-23 or PCV-13 pneumonia vaccinations. On 9/1/16, at 9:13 a.m. the administrator verified there were no medical records indicating R26 had been offered nor immunized for pneumonia. R40 was 77 years old, and had been admitted to the facility in 6/15. Immunization and medical records revealed the resident had not been informed of, was offered or had received either PCV-23 or PCV-13. On 9/1/16, at 9:13 a.m. the administrator verified there were no medical records for Pneumovax being offered or administered to the resident. R14 was 93 years old, and was admitted to the facility in 4/11, and had diagnoses including heart disease. Immunization records indicated "Pneumovax Risk/Benefits given: 9/29/15. Pneumovax administered: 1/28/11." The record did not specify if the second PCV-23 or the PCV-13 had been offered. R7 was 88 years old and had been admitted to the facility in 8/14 with diagnoses including heart disease, chronic obstructive pulmonary disease and diabetes. Vaccination records revealed Pneumovax administered: 7/18/07. Pneumovax Risk/Benefits given: 9/29/15, however, the records did not specify whether the second PCV-23 or the PCV-13 had also been offered. R33 was 86 years old and had diagnoses including heart disease. In addition, records showed Pneumovax had been refused on	F 334	vaccines had been offered to all residents as appropriate. Any resident identified to have not received or been offered the pneumococcal vaccine was offered the vaccine by 10/11/16. 3. A new policy was developed and implemented on 9/27/16 that included guidelines that included Pneumococcal Conjugate Vaccine (PCV)-13 consistent with current CDC recommendations. Our procedure will be for the Resident Care Coordinator or DON to identify new admissions needing to be offered the pneumococcal vaccine based on documentation available. If there is no record of vaccine being administered, RCC or DON will provide education to the resident (or responsible party) and offer the vaccine to the resident. Education regarding our new policy and procedure will be provided to all nurses by 10/11/16. 4. Audits will be completed on up to 5 newly admitted residents each week in addition to 5 random residents by the DON or designee each week for 4 weeks and then monthly for 3 months to ensure residents are educated regarding pneumococcal vaccines, the vaccines are offered to resident, and that they are documented appropriately. Audit results will be reported to the Quality Assurance Committee for review at the next Quality Assurance meeting.	

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F 334	Continued From page 10 5/23/14, and the risks and benefits of immunization had been provided to the resident's representative at that time, however, no further evidence was noted Pneumovax had since been offered for R33. The director of nursing (DON) verified in an interview on 9/1/16, at 8:28 a.m. no resident in the facility had been offered or administered the PCV-13 yet and stated the nurses had not been following the protocol related to the information on the facility form titled "Pneumococcal Conjugate Vaccine." The DON explained when a resident was admitted to the facility they were screened to see if they had received the PCV-23 if not they were given the consent form with the risk and benefits and offered it. Then if the residents were recommended by the CDC to receive the PCV-13 based on their diagnoses a call was placed to the physician to get the okay to give or not to give. The DON verified there was no a policy or procedure instructing the nurses on how or what to do if a residents met the recommendations to receive the PCV-13. On 9/1/16, at 9:13 a.m. the administrator verified he could not find any documentation that R26 and R40 ever received the PCV-23 vaccine prior or since admission. In addition, the administrator reported the facility did not have a policy and procedure at this time that included the CDC's recommendations for PCV-13.	F 334		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431		10/11/16

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F 431	Continued From page 11 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to discard expired blood collection laboratory tubes for 3 of 5 residents (R12, R17, R27) receiving laboratory testing and failed to maintain optimal storage temperatures	F 431	1. Residents 12, 17, and 27's expired laboratory tubes were immediately disposed of. Appropriate laboratory tubes were used in drawing labs for these residents. Resident 1 and 26's	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 12 for 2 of 2 residents (R1, R26) whose insulin was being stored in the refrigerator. Findings include: During a medication storage observation with registered nurse (RN)-A on 8/29/16, at 7:14 p.m. three tubes with light blue tops, four with yellow tops , four with lavender tops and three with red tops (14 total collection laboratory tubes had expired. RN-A verified all the tubes had expired dates and stated, "I see those tubes are expired, but I really don't know about these because I do not draw blood." The director of nursing (DON) then verified tubes had expired and stated, "We are not really using those tubes. They are just for back up. That is why probably nobody had checked on them. We use the ones in the office on first floor which is in the blood draw kit." The surveyor and DON then went to observe to tubes the DON reported were currently in use. Ten unlabeled laboratory tubes and three labeled with lavender tops and one with a blue top blood collection laboratory tubes for R27, R12 and R17 were found expired, as well as labeled tubes for R27, R12 and R17 for the following day's blood draw on 8/30/16. The DON stated, "This is a problem, and I am responsible to make sure things are right. It is a definitely a problem. The expiration date should have been checked. It is also wrong--the tube should not be labeled up front [in advance]. I will talk to the person who is doing the blood draw and correct it right away." Ann interview was conducted on 9/01/16, at 9:17 a.m. with licensed practical nurse (LPN)-A who was responsible drawing and collecting blood samples. LPN-A stated, "It was wrong. The expired tube should not be in the blood draw kit. I	F 431	medications were immediately moved to a different refrigerator. Maintenance recalibrated the refrigerators in east and south medication rooms. 2. All residents have the potential to be affected. 3. Prior to conducting any laboratory work, nurse will verify that each laboratory tube is in usable condition and not expired. Laboratory tubes will not be labeled until after the lab work is taken from the resident. Lab tubes will be labeled immediately following each lab draw from a resident. All nurses will be educated on this procedure by 10/11/16. Refrigerator temperatures will be observed and recorded once per shift daily by the nurse on duty. Any temperatures outside of the 36 to 40 degrees F range will be reported to maintenance and medications moved to an alternative refrigerator if necessary. 4. Audits will be conducted weekly by the DON or designee of lab draws for up to 5 random residents for 4 weeks and then monthly for 3 months to ensure no expired tubes are being used and that laboratory tubes are being labeled appropriately. Audits of medication room refrigerator temperatures will be conducted daily for 4 weeks by the DON or designee to ensure temperatures are within appropriate range. Audit results will be reported to the Quality Assurance Committee for review at the next Quality Assurance meeting.	

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	245395	A. BUILDING _____ B. WING _____	09/01/2016

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have used them before and I did not check every one of them for expiration dates. I am not going to assume anymore. I must look at every tube. I also did not know labeling the tube up front was wrong--now I know--I am not going to do that either. I have ordered new tubes with the same expiration date and I will watch for the expiration day closely now."

R17 had a physician's order dated 7/28/16, for "Renal function panel in 4 weeks."

R27 had laboratory orders dated 8/30/16, to perform per standing orders "HgbA1c."

R12 had routine orders every six months for laboratory work that read, "CMP, CBC ,B12 and Lipid Panel."

On 8/29/16, at 6:56 p.m. in the South unit medication room was observed with RN-C, who verified three with blue tops had expired 4/16, four with gold tops had expired 12/15, and four with purple tops had expired 7/16. RN-C stated, "We only use these lab tubes when lab [staff] does not come, but usually I run downstairs and use the lab supplies down there." RN-C explained she was the backup laboratory staff person at the facility.

The facility's undated Obtaining Blood Specimens from a Direct Venipuncture policy indicated "The purpose of this procedure is to provide guidelines for the safe and aseptic sampling of there resident's blood via direct venipuncture."

The Food and Drug Administration recommends storage of insulin between 36 and 40 degrees per

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manufacturer's instructions for optimal viability of the insulin product. However, on 8/29/16, at 6:56 p.m. RN-C verified the medication refrigerator in the South unit medication room was only 33 degrees Fahrenheit. RN-C also verified on the log posted on the refrigerator indicated the temperature on the refrigerator on 8/3, 8/4 and 8/5/16, was only 34 degrees with "adj" [adjusted] written in a column with no follow up temperature taken after the adjustment. RN-C stated the log form indicated refrigerator temperatures should have been kept between 36 to 41 degrees. RN-C verified on the temperature log the temperature and notations of 8/25/16, and R1's Humalog (insulin) vial was being stored in the refrigerator with a pharmacy date of 8/28/16. RN-C verified R26's flexpen Novolog Mix (insulin) was unopened in the refrigerator.

At 7:20 p.m. RN-D stated night staff checked the refrigerator temperatures. RN-D stated if the refrigerator temperature was lower than 36 degrees staff were to adjust the dial and return usually an hour later to recheck the temperature. RN-D stated if the temperature was then not in range maintenance was to be notified and staff was to report it to the oncoming shift.

On 8/30/16, at 11:08 a.m. RN-C stated she had talked to the DON about the medication refrigerator and rechecked the refrigerator about an hour later and then replaced it with a new thermometer with a new thermometer from the kitchen, which she placed in the middle of the shelf. At 11:21 a.m. RN-E stated it was reported in report that the medication refrigerator was too chilly. RN-E verified the thermometer in the refrigerator was "41-42" degrees and stated she planned to move the thermometer, recheck it in

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an hour, and document the results on the log RN-E stated "Usually nights just check the temperature unless we open up the refrigerator and find things frozen" or not cold enough.

Later that afternoon at 3:27 p.m. RN-A verified the medication refrigerator temperature was 31 degrees and she again adjusted the dial. RN-A stated she normally just adjusted the dial, came back and rechecked in an hour, but did not record the temperature, as "just nights" did so. RN-A verified an unopened Humalog insulin vial for R1 and an unopened Flex Pen Novolog Mix 70/30 for R26 were stored in the refrigerator. RN-A stated she had never noticed the temperature being out of range in the past.

At 3:33 p.m. RN-E stated she had checked the refrigerator at 1:00 p.m. and it registered 36 degrees.

On 8/30/16, at 5:09 p.m. RN-C verified the refrigerator was 32 degrees and turned the dial from "4 to 5".

On 8/30/16, at 5:16 p.m. RN-A stated she had checked an hour later and adjusted the dial up from "3 to 4".

On 8/30/16, at 5:17 p.m. RN-C stated she had reported the issue to maintenance staff, and had removed R1 and R26's insulin and moved them to the refrigerator on the other unit. She planned to inform the floor nurse of that unit and the DON.

On 8/30/16, at 5:18 p.m. the maintenance staff reported he had placed the thermometer in the middle of the bottom shelf and planned to check it in the morning. He thought perhaps the

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thermometer had been placed too close to the freezer portion of the refrigerator.

On 8/30/16, at 5:52 p.m. the DON stated the night nurse checked the temperature of the refrigerator nightly, which the DON reviewed monthly. The DON though maybe they should have been reviewed more often.

The following morning at 7:50 a.m. the maintenance staff stated he had checked the temperature of the medication refrigerator earlier and it was "42" degrees and stated he had thought it was okay but then saw the range listed on the log form and realized it was too high and not within range. Maintenance stated he had opened the refrigerator door back up in just "30 seconds" and the thermometer read "44" degrees.

Review of the South refrigerator log indicated temperatures documented as following:
8/3/16, 34 degrees
8/4/16, 34 degrees
8/5/16, 34 degrees
8/25/16, 35 degrees
8/29/16, 32 degrees
8/30/16, 31 and 32 degrees
8/31/16 42 degrees

Review of the East Med Room refrigerator log indicated temperatures documented as following:
8/10/16, 34 degrees
8/11/16, 32 degrees
8/13/16, 34 degrees
8/14/16, 44 degrees
8/15/16, 42 degrees
8/16/16, 30 degrees
8/20/16, 46 degrees

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F 431	Continued From page 17 8/21/16, 34 degrees 8/23/16, 30 degrees 8/24/16, 34 degrees 8/25/16, 42 degrees 8/26/16, BLANK 8/27/16, 48 degrees 8/28/16, 42 degrees On 8/31/16, at 7:51 a.m. DON stated she could give the staff better instruction regarding monitoring of medication refrigerator temperatures. The facility's undated Storage of Medications policy indicated "The facility shall store all drugs and biologicals in a safe, secure, and orderly manner...The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner...The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All drugs shall be returned to the dispensing pharmacy or destroyed."	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		10/11/16

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F 441	Continued From page 18 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly disinfect a shared glucometer for 8 of 8 residents (R27, R11, R26, R1, R16, R7, R41, R13) who utilized the glucometer for blood sugar monitoring. Findings include: R27's blood sugar was taken on 8/30/16, at 11:13 a.m. by registered nurse (RN)-B who wiped R27's finger with an alcohol wipe, waved the air over finger couple of seconds, then pricked the	F 441	1. Immediate education was provided to nurses on duty regarding glucometer cleaning procedure for residents 27, 11, 26, 1, 16, 7, 41, and 13 as well as for all residents. 2. All residents have the potential to be affected. 3. New procedure for cleaning glucometers per the manufacturer's directions were created and implemented	

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F 441	Continued From page 19 resident's finger with a lancet. RN-B informed R27 of the reading and told her she would return with her insulin. RN-B placed the the lancet in the sharps container and removed her gloves. RN-B went to the medication cart and removed a Sani Wipe from the purple lid container and wiped around the glucometer for 2-3 seconds, then set the glucometer on a cloth white towel on top of the cart. RN-B explained "I wipe around the glucometer for three seconds, just to wipe it off and then to allow to air dry on top of the cart." R11's blood sugar was observed with RN-A on 8/30/16, donned gloves and took a drop of blood from R11;s finger and placed it on the strip. RN-A discarded the strip, lancet and removed her gloves,and reported the results to R22 and told the resident she would return with her insulin. While wearing the same gloves, RN-A proceeded to the medication cart, where she removed a Sani Wipe from he container and wiped the glucometer for 2-3 seconds and then laid the glucometer on a tissue. RN-A reported they sanitized glucometers for three seconds with a Sani Wipe and then allow them to air dry. RN-A reported, "We are trained to clean it that way." RN-A then verified the Sani Wipe canister instructions read, "Use first germicidal wipe to remove heavy soil. Use second germicidal wipe to thoroughly wet surface. Allow to remain wet two [2] minutes, let air dry." RN-A versified the glucometer was shared by other residents. On 8/30/16, at 5:28 p.m. RN-C stated shared glucometers were used for R11, R26, R1 and R16. RN-C stated staff were to take a purple Sani Wipe and wipe the glucometer for 2-3 minutes and make sure the glucometer stayed wet for 2-3 minutes. RN-C stated they alternated between	F 441	8/31/16. Education will be provided on the new procedure for all nurses by 10/11/16 and a return demonstration provided in front of the DON or designee to verify compliance with manufacturer's recommendation for properly cleaning glucometers. 4. Audits will be conducted by the DON or designee weekly for 4 weeks and monthly for 3 months for up to 5 glucometer uses on 5 random residents to ensure proper disinfecting procedure is followed. Audit results will be reported to the Quality Assurance Committee for review at the next Quality Assurance meeting.	

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two glucometers so as not to slow down the process because of cleaning.

At 5:38 p.m. the director of nursing (DON) stated two glucometers were used for the South unit. Glucometers were to be cleaned after each use, with a purple Sani Wipe, wiping the entire surface and to allow for an unspesified wet time. The DON then explained that the glucometer was then to be placed on a barrier paper towel, and then the second cleaned glucometer could be used. The DON said it had been her responsibility for not properly instructing the nurses how to clean the glucometers according to product instructions. She planned to ensure the policy was correct and staff were educated. The DON stated there were eight residents who utilized the two devices including R27, R11, R26, R1, R16, R7, R41 and R13.

The following morning on 8/31/16, at 7:59 a.m. the administrator provided a form explaining they had provided instruction for all nurses as they came to work regarding the proper sanitization of the glucometers.

The facility's undated Directions for disinfecting glucometers using Sani-Cloth Germicidal Disposable Wipes policy indicated "...Because there is blood involved (even if it is only a microscopic amount) we must disinfect the glucometer using 2 Sani-Cloths 5. Use the 1st Sani-Cloth to wipe down the entire Glucometer, specifically around the area where the test strip is inserted into the Glucometer...Use a 2nd Sani-Cloth to thoroughly wet surface and wrap the cloth around Glucometer in order to allow surface to remain wet for 2 minutes..Then let the surface air dry...Dispose of gloves...Wash your

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F 441	Continued From page 21 hands."	F 441		

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	245395	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/30/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on August 30, 2016. At the time of this survey, Crossroads Care Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/28/2016

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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K 000	Continued From page 1 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Crossroads Care Center was constructed as follows: The original building was constructed in 1953, is one-story in height, has a full basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1968 Addition is one-story in height, has a full basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The facility has smoke detection in the corridors and spaces open to the corridors, which are monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 36 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire	K 029		10/11/16

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 2 extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 FINDINGS INCLUDE: During Facility Inspection on August 30, 2016, between 10:00 AM and 1:00 PM, the following deficiencies in Hazardous Areas were noted during the inspection: a.) The Main and Back Kitchen doors were observed needing self door closers and doors that latch into the door frames. Both of these doors open directly into a cooridor outside of the kitchen. b.) The Soiled Utility Room Door (C-12) was observed needing a door that latches into the door frame. These deficient practices were observed by the Facility Maintenance Director.	K 029	1. The main kitchen door and back kitchen door will have new self-closing devices installed and will be adjusted to ensure that they close and latch appropriately. 2. This will be completed by 10/11/16 3. The Maintenance Supervisor will be responsible for correction and monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/30/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 048 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 FINDINGS INCLUDE: During Facility Inspection on August 30, 2016, between 10:00 AM and 1:00 PM, it was observed that the posted emergency evacuation diagrams in the corridors do not show the routes to exits or location of fire emergency equipment. This deficient practice was observed by the Facility Maintenance Director.	K 048	1. New evacuation plans will be created to include exit routes and the location of fire emergency equipment. 2. This will be completed by 10/11/16 and the updated evacuation plans will be posted by 10/11/16. 3. The Administrator will be responsible for correction and monitoring.	10/11/16