### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

					AND TRANSMITTAL TE SURVEY AGENCY		D: O4BD facility ID: 00470
1. MEDICARE/MEDICAID PROVIDER N           (L1)         245251           2.STATE VENDOR OR MEDICAID NO.         (L2)         861347800	iO.	3. NAME AND ADI (L3) RIVERVIEW (L4) 323 SOUTH 1 (L5) CROOKSTO	/ HOSPITAL & N MINNESOTA		HOME (L6) 56716	<ol> <li>TYPE OF ACTION:</li> <li>1. Initial</li> <li>3. Termination</li> <li>5. Validation</li> <li>7. On-Site Visit</li> </ol>	7(L8) 2. Recertification 4. CHOW 6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF OW (L9)	NERSHIP	7. PROVIDER/SUP 01 Hospital	PLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Co	
6. DATE OF SURVEY 03/12 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING 09/30	DATE: (L35)
11LTC PERIOD OF CERTIFICATION         From (a):         To (b):         12. Total Facility Beds         13. Total Certified Beds         14. LTC CERTIFIED BED BREAKDOWN         18 SNF       18/19 SNF         24         (L37)       (L38)         16. STATE SURVEY AGENCY REMARK	19 SNF (L39)	B. Not in Comy Requireme ICF (L42)	ce With quirements Based On: cceptable POC bliance with Program nts and/or Applied W IID (L43)	/aivers:	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Servic 7. Medical Direct	or
17. surveyor signature	•		)3/18/2015	(L19)	18. STATE SURVEY AGENCY AP	, Enforcement Specia	Date: 03/18/2015 (L20)
19. DETERMINATION OF ELIGIBILITY         _X_       1. Facility is Eligible to Par          2. Facility is not Eligible	7	20. COM	D BY HCFA RE PLIANCE WITH CI ITS ACT:		21. 1. Statement of Financ 2. Ownership/Control 1 3. Both of the Above :		1-1513)
22. ORIGINAL DATE OF PARTICIPATION 08/01/1982 (L24)	23. LTC AGREEMI BEGINNING I (L41)		4. LTC AGREEMEN ENDING DATE (L25)		26. TERMINATION ACTION:         VOLUNTARY       00         01-Merger, Closure         02-Dissatisfaction W/ Reimburseme	INVOLUNT 05-Fail to Me	L30) <u>ARY</u> seet Health/Safety seet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI A. Suspension o B. Rescind Susp	of Admissions:	(L44) (L45)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	<u>OTHER</u> 07-Provider 00-Active	Status Change
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C. 03001		(L31)	30. REMARKS Posted 03/24/2015 Co		
31. RO RECEIPT OF CMS-1539	32 (L32)	. DETERMINATION C 03/11/2015	DF APPROVAL DAT	E (L33)	DETERMINATION APPRO	VAL	



Protecting, Maintaining and Improving the Health of Minnesotans CMS Certification Number (CCN): 245251

March 18, 2015

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

Dear Mr. Mielke:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective March 10, 2015 the above facility is certified for:

24 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

-Mark Meath

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



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered March 18, 2015

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

**RE:** Project Number

Dear Mr. Mielke:

On February 6, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 23, 2015 that included an investigation of complaint number. 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 March 12, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 23, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 10, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 23, 2015, effective March 10, 2015 and therefore remedies outlined in our letter to you dated February 6, 2015, 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, 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

5251r15

#### **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 245251	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 3/12/2015
Name	of Facility		Street Address, City, State, Zip Code	
Rľ	VERVIEW HOSPITAL & NURSING HOME		323 SOUTH MINNESOTA CROOKSTON, MN 56716	

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

(Y4) Item	(Y5	) Date	(Y4) Item	(Y5)	Date (	Y4) Item	(	Y5)	Date
ID Prefix	F0280	Correction Completed _03/10/2015	ID Prefix	F0329	Correction Completed _03/10/2015	ID Prefix	F0356		Correction Completed 03/10/2015
	483.20(d)(3), 483.10(k)(2)	_	Reg. # LSC	483.25(1)	-	, v	483.30(e)		_
LSC		-	LSC						_
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		_			-				_
Reg. # LSC		-	Reg. # LSC		-	Reg. # LSC			_
		-			-				
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed				Completed
		_	Reg. #		-	Reg. #			_
Reg. # LSC		_			-				_
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix			Completed
Reg. #		_	Reg. #		-				_
LSC		-	LSC		-	LSC			_ _
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		-	ID Prefix		-	ID Prefix			_
Reg. # LSC			Reg. # LSC			Reg. #			_
		-	E3C		-				_
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	eyor:	1		Date:	
State Agency	/ LB/mr	n	03/18/20	28	035			03/12	2/2015
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	eyor:			Date:	
CMS RO									
Followup to	Survey Completed on:					eficiencies. Was			
	1/23/2015			Uncorrecte	a Deficiencies (	CMS-2567) Sent	to the Facility?	YES	NO

DEPARTMENT OF HEALT						DICARE & MEDICAID SERVICES		
	-		-		AND TRANSMITTAL	ID: O4BD		
		1			TE SURVEY AGENCY	Facility ID: 00470		
1. MEDICARE/MEDICAID PROVID (L1) 245251	DER NO.	3. NAME AND AI (L3) RIVERVIE			NG HOME	4. TYPE OF ACTION: <u>2</u> (L8)		
2.STATE VENDOR OR MEDICAID	NO.	(L4) 323 SOUTH				1. Initial2. Recertification3. Termination4. CHOW		
(L2) <b>861347800</b>		(L5) CROOKSTO	ON, MN		(L6) <b>56716</b>	5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEG	JORY	<u>02</u> (L7)	7. On-Site Visit 9. Other		
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 01/2	<b>3/2015</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/III				
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30		
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:		
To (b) :			equirements e Based On:		2. Technical Personnel	_ · · · · · · · · · · · · · · · · · · ·		
12. Total Facility Beds	<b>24</b> (L18)	1	cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN	<ul> <li>T. Medical Director</li> <li>NF) 8. Patient Room Size</li> </ul>		
12. Total Fuolity Doub	24 (210)				5. Life Safety Code	9. Beds/Room		
13. Total Certified Beds	<b>24</b> (L17)	X B. Not in Con Requirem	npliance with Prog ents and/or Appli	gram ied Waivers:	* Code: <b>B</b> *	(L12)		
14. LTC CERTIFIED BED BREAKDO	OWN	•			15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
24								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Jane Aandal, HFE NI	EII	0	03/05/2015	(L19)	) Mark Meath, Enforcement Specialist 03/09/2015 (L20			
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	EGIONA	L OFFICE OR SINGLE S	STATE AGENCY		
19. DETERMINATION OF ELIGIBI	LITY		IPLIANCE WITH	H CIVIL		ncial Solvency (HCFA-2572)		
1. Facility is Eligible to	Participate	RIGI	HTS ACT:		<ol> <li>Ownership/Contr</li> <li>Both of the Above</li> </ol>	ol Interest Disclosure Stmt (HCFA-1513) e :		
2. Facility is not Eligible								
	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	: (L30)		
OF PARTICIPATION	BEGINNING	<b>J</b> DATE	ENDING DA	TE	VOLUNTARY 0	INVOLUNTARY		
08/01/1982					01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs			
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER		
	A. Suspension	n of Admissions:	(1.44)		04-Other Reason for whiterawar	07-Provider Status Change 00-Active		
(L27)	B. Rescind St	uspension Date:	(L44)			00-2 101/10		
		Ĩ	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS			
		03001						
	(L28)	00001		(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE	Posted 03/11/2015 C	.0.		
	(L32)			(L33)	DETERMINATION APP	ROVAL		



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered February 6, 2015

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

RE: Project Number S5251036

Dear Mr. Mielke:

On January 23, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

## DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor Bemidji Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: Lyla.burkman@state.mn.us

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

## **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 4, 2015, 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 April 23, 2015 (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 July 23, 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 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

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

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

Sincerely,

## Mark Weath

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

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

5251s15

DEPART	MENT OF HEALTH	AND HUMAN SERVICES		· ·		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-	0	MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY IPLETED
		245251	B. WING		01/	23/2015
NAME OF F	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
RIVERVI	EW HOSPITAL & NUF	RSING HOME		323 SOUTH MINNESOTA CROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	rs	F 00	0		
F 280 SS=D	as your allegation of Department's accep enrolled in ePOC, y at the bottom of the form. Your electror be used as verificat Upon receipt of an on-site revisit of you validate that substar regulations has bee your verification. 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has the incompetent or othe incapacitated unde participate in plann changes in care an A comprehensive as interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p the resident, the resi legal representative	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with 0(k)(2) RIGHT TO NNING CARE-REVISE CP he right, unless adjudged erwise found to be r the laws of the State, to ing care and treatment or	F 28			3/10/15
		DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE
Electron	ically Signed					03/04/2015

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.

# PRINTED: 03/05/2015

	-	AND HUMAN SERVICES				FORM	03/05/201 APPROVE 0938-039
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245251	B. WING			01/2	23/2015
NAME OF I	PROVIDER OR SUPPLIER	-		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	RSING HOME			23 SOUTH MINNESOTA ROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 280	Continued From pa	ige 1	F 2	280			
	This REQUIREMEN	NT is not met as evidenced					
	Based on interview facility failed to revis residents (R9) to in antipsychotic medic Findings include: R9's physician's ord Seroquel 25 milligra psychosis/paranoia R9's care plan revie use of an antianxie Seroquel was not a any behavioral sym the Seroquel. On 1/22/15, at 11:5 (DON) stated they behavior" for the us wanted to talk with determine how they verified the Seroque the target behavior.	der dated 12/1/14, read ams (mg) at bedtime for  ewed 11/20/14, addressed the ty medication. However, the ddressed on the care plan or ptoms related to the use of 5 a.m. the director of nursing had not determined the "target se of the Seroquel yet, and she registered nurse (RN)-B to y should word it. The DON el was not on the care plan or . The DON stated the care d quarterly and stated they try			-For the resident in question, the c plan was revised on 1/27/15 to inclu administration of Seroquel. Care pl updated for monitoring of interventi well on 1/27/15. Survey results and for improvement were discussed at staff meeting. -All care plans are reviewed quarte re-written annually. Care plans are updated on an ongoing basis as ch arise with their needs and care leve After any new psychotropic medical started, the charge nurse will updat care plan and implement clinical monitoring. All residents receiving a psychotropic medication will have a of care in place that addresses this Resident target behaviors are ident with assessment upon admission a included in initial care plan for mon When new or worsening behaviors identified, care plan is updated to re these changes so staff can implem appropriate interventions.Care plan updated with interventions that are individualized for that resident. -Follow-up of any new psychotropic medication will be checked by DON	ude the an was ions as I plans t 2/3/15 rly and also hanges els. tion is te the a plan tified and itoring. are eflect ent hs are	
	read problem beha the resident's Plan updated with any cl approach, resident' the addition of a ps	toring policy reviewed 3/97, viors were also documented in of Care. This information was nange in the behavior, staff's s ability to be redirected and ychotropic medication. Identify 'target" behaviors. Add			or MDS Coordinator the following business day to ensure care plans updated correctly. Policy and proce related Behavior monitoring have b reviewed and new policy related to maintaining care plan compliance w implemented. Ongoing communicat pertaining to the plan of corrections	edures been will be itions	

Facility ID: 00470

If continuation sheet Page 2 of 11

		AND HUMAN SERVICES				FORM	03/05/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION ()		E SURVEY PLETED
		245251	B. WING			01/2	23/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	RSING HOME			23 SOUTH MINNESOTA ROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
	483.25(I) DRUG RE	goals, and interventions to the care plan.	F 2 F 3		occur at monthly staff meetings. -Care plans for residents receiving psychotropic medication will be audit the Director of Nursing monthly for 3 months of consecutive compliance th decreased to quarterly for 3 quarters consecutive compliance. Audit findin will be discussed at IDT meetings as as quarterly quality improvment meeting	hen s of gs s well	3/10/15
SS=D	unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer should be reduced combinations of the Based on a compre- resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and o record; and residen drugs receive gradu behavioral interven	g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any					

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		& MEDICAID SERVICES			<u>OMB NO.</u>	
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · ·	E SURVEY PLETED
		245251	B. WING		01/2	23/2015
NAME OF	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NU	RSING HOME		323 SOUTH MINNESOTA CROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 329	Continued From pa	age 3	F 32	0		
		NT is not met as evidenced	1 02			
	Based on observa review, the facility f (R9) had adequate of an anti-psychotic Findings include: R9's admission Mir 11/12/14, indicated impairment. The M behavior symptoms Care Area Assessm indicated R9 did ge easily relieved. Ver Psychotropic CAA was lacking. On 1/22/15, at 7:06 day room in the rec watching a musical	tion, interview and document ailed to ensure 1 of 3 residents indications warranting the use c (Seroquel) medication. himum Data Set (MDS) dated R9 had severe cognitive DS did not include any s noted for R9. The Cognitive nent (CAA) dated 11/12/14, et anxious a little bit, but was y pleasant and sociable. A should have completed but		<ul> <li>The resident involved in this situlated care plan reviewed by staff a plan was updated to include target behaviors and appropriate intervet on 1/27/15. Survey results and plaimprovement were discussed at 2 staff meeting.</li> <li>Target behaviors are identified up admission and revised quarterly a as the residents needs change. N worsening behaviors will be discussed at a ster residents needs change. N worsening behaviors will be ide prior to initiation of said medication interdisciplinary team. Changes in resident behavior will be addressed weekly and as needed by IDT.</li> <li>Care Plans will be tailored to me individualized needs of the resident provide clear interventions to staff on how to be forwered to the provide clear interventions to staff on how to be forwered by the provide clear interventions to staff on how to be forwered to me individualized needs of the reside plan of care will provide clear interventions to staff on how to be forwered to me individualized needs of the reside plan of care will provide clear interventions to staff on how to be forwered by the provide clear interventions to staff on how to be forwered to me individualized needs of the reside plan of care will provide clear interventions to staff on how to be forwered to me individualized needs of the reside plan of care will provide clear interventions to staff on how to be forwered to me individualized needs of the reside plan of care will provide clear interventions to staff on how to be forwered to me individualized needs of the reside plan of care will provide clear interventions to staff on how to be forwered to me individualized needs of the reside plan of care will provide clear interventions to staff on how to be forwered to me individualized needs of the reside plan of care will provide clear interventions to staff on how to be forwered to me individualized needs of the reside plan of care will provide clear interventions to staff on how to be forwered to me individualized needs of the reside plan of care will pr</li></ul>	nd care entions ans for 2/3/15 con and PRN lew or ssed ons for ntified on by n ed et the nt. This est care	
	the hallway with he conversational with R9's admission ord Xanax (anti-anxiety bedtime and three The physician's pro- indicated R9 had b had become more elope several times	5 a.m. R9 was ambulating in r walker. R9 was		for residents and their needs. Rest target behaviors are identified wit assessment upon admission and in initial care plan for monitoring. new or worsening behaviors are i care plan is updated to reflect the changes so staff can implement appropriate interventions. Care P include valid indications of use fo psychotropic medications. In addic care plans will indicate non-pharmacological intervention prior to medication intervention. F registered to participate in the Na Nursing Home Quality Care Colla	h included When dentified, se lans will r all tion, s to try facility is tional	

Facility ID: 00470

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	E CONSTRUCTION		0938-039
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG _		COM	PLETED
		245251	B. WING _			01/2	23/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NU	RSING HOME			23 SOUTH MINNESOTA ROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 329	Continued From pa	age 4	F 32	29			
	to R9's primary phy information. Reside Had paranoid beha room after being cl wanted to know if s like it, "If I am not s is a new statement advise, Thank You On 12/1/14, the pri Seroquel 25 mg at behaviors. However resident's condition symptoms could be non-pharmacologic implementing the u medication was lace	mary physician ordered bedtime for paranoid er, an assessment of the to determine if behavioral e modified with cal interventions versus use of an antipsychotic cking.			practices for reducing antipsychot medication and identifying the besi interventions to provide residents least restrictive environment possi Ongoing communications pertaining plan of corrections will occur at me staff meetings. - Policy has been reviewed and wi updated to reflect these changes a nursing staff will be re-educated o identifying appropriate indications for all behavioral modification interventions. Audits will be compl Director of nursing monthly for 3 n of consecutive compliance then decreased to quarterly for 3 quarter consecutive compliance. Audit find will be discussed at IDT meetings as quarterly quality improvment me	t with ble. ng to the onthly II be and for use eted by nonths ers of dings as well	
	records (MAR) dat January 2015, R9 d during the months received 1 PRN do to increased crying being "helped."	edication administration ed November 2014, through did not receive any Xanax PRN of November or January. R9 use of Xanax on 12/22/14, due and irritation, with the results ewed 11/20/14, addressed the					
	use of an antianxie Seroquel was not a	addressed the addressed on the care plan or aptoms related to the use of					
	indicated R9 was r month ago. After a started having a lo	ogress note dated 12/17/14, ecently admitted about a few days of being admitted R9 t of behavioral issues. R9 was opriately and was having					

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CENTER STATEMENT AND PLAN C	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER EW HOSPITAL & NUF	AND HUMAN SERVICES  & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245251  RSING HOME  TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	. ,	S 32 C		FORM MB NO. (X3) DATE COM 01/2	03/05/2015 APPROVED 0938-0391 E SURVEY PLETED 23/2015 (X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE
F 329	paranoia and agitat manage for the staf On 1/22/15, at 8:54 (DON) stated RN-C 11/29/14, as a FYI ( inform the physiciar think RN-C was loo The DON stated RS behavior about peo DON stated the par documented in the The behaviors bein assistants (NA) on f January 2015 beha -attempts to exit ser- wandering -verbal agitation/ab On 1/22/15, at 9:27 come out of her roc stealing all of her st able to state what p stated she would hi closet and in the dra also hide hangers in take them. RN-B st they had taken all o dresser drawer. RN staff that all the pull drawer so more we At 11:55 a.m. the D find a policy related The DON provided which read, "target shift." The DON sta	<ul> <li>a.m. the director of nursing</li> <li>b.ad faxed the physician on (for information only) just to</li> <li>n. The DON stated she did not off.</li> <li>b.ad faxed the physician on (for information only) just to</li> <li>n. The DON stated she did not off.</li> <li>b. Was having paranoid ople going into her room. The ranoid behaviors would be nurses notes.</li> <li>g monitored by the nursing the December 2014, and ovior forms were: cured doors</li> <li>cured doors</li> <li>cured mand stated people were tuff. RN-B stated R9 would on and stated people were tuff. RN-B stated R9 would on the drawer so no one would rated R9 had stated to her, see of this, referring to the top I-B then found out from the I ups were gone from the top</li> </ul>	F	329			

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		AND HUMAN SERVICES				FORM	03/05/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245251	B. WING			01/:	23/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	ISING HOME			23 SOUTH MINNESOTA CROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 329	yet, and she wanted determine how they verified the Seroque the target behavior. At 1:00 p.m. NA-E s every Tuesday. NA- doing R9's bath in t would get up at 6:00 be crabby for the re does not like to cha she now gives R9 h goes well. NA-E sta would wash her clor and she accepted th heard R9 being par stated R9 does thin things. At 1:13 p.m. the con stated a diagnosis of diagnosis to warran CP stated R9 had c week prior to her re would also want to exhibited that would At 6:00 p.m. R9's fa interviewed via pho the phrase "I will kil stated R9 would be room at all. She did she thought people when they saw the see R9 getting mor was huffing and put physician did not wa	d to talk with RN-B to / should word it. The DON el was not on the care plan or		329			

Facility ID: 00470

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	<u>OMB NO</u> (X3) DAT	E SURVEY
ND PLAN C	OF CORRECTION	DENTIFICATION NUMBER:		NG	CON	IPLETED
		245251	B. WING _		01	23/2015
NAME OF I	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
RIVERVI	EW HOSPITAL & NU	RSING HOME		323 SOUTH MINNESOTA CROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 329	was a necessity. F irritated and negat then she would try stated, "I would ha tried the Xanax firs been on a medicat R9 had been a priv to share things wit On 1/23/15, at 8:5 the day R9 was su The administrator intent was not to g medication. The D the Seroquel until	M-A stated R9 would seem ive when she came to visit and and change the topic. FM-A ve thought they would have st." FM-A stated R9 had never ion for paranoia. FM-A stated vate person who does not want h family members. 4 a.m. the DON stated during spicious about other residents. stated at that time that the et R9 on an antipsychotic ON stated they could not start they received prior efore, the Seroquel was not	F 32	29		
F 356 SS=C	read problem beha the resident's Plan updated with any of approach, resident the addition of a pa individual resident behavior concerns individual resident 483.30(e) POSTEI INFORMATION The facility must p a daily basis: o Facility name. o The current date o The total numbe by the following ca	O NURSE STAFFING	F 35	56		3/10/15

Facility ID: 00470

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	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MET	PLE CONSTRUCTION		0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
		245251	B. WING		01/2	23/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE	
RIVERVI	EW HOSPITAL & NU	RSING HOME		323 SOUTH MINNESOTA CROOKSTON, MN 56716		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETIC
F 356	Continued From pa	age 8	F 35	6		
	resident care per s	-				
	<ul> <li>Registered nu</li> </ul>	urses.				
		ctical nurses or licensed				
	vocational nurses - Certified nurs	(as defined under State law).				
	o Resident census					
		ost the nurse staffing data				
		a daily basis at the beginning				
	of each shift. Data	n must be posted as follows:				
		ace readily accessible to				
	residents and visite					
	make nurse staffin	pon oral or written request, g data available to the public t not to exceed the community				
	staffing data for a i	aintain the posted daily nurse ninimum of 18 months, or as aw, whichever is greater.				
		NT is not met as evidenced				
	by: Based on observa	tion intonviow and document		Nurso staffing hours form h	as boon	
		tion, interview, and document failed to ensure the nurse		-Nurse staffing hours form h reviewed and updated with c		
		ate regarding the number of		posting information. Survey		
	nursing staff and a	ctual hours worked per shift for		plans for improvement were		
		iewed. This had the potential		2/3/15 staff meeting.	atad in the	
	as well as any visit	dents who resided in the facility		-Nurse staffing hours are post common area of nursing hor		
	as well as ally visit	015.		accessible to residents and		
	Findings include:			Current policy has been revis be updated to include the sp	sed and will	
	During the initial to	ur on 1/21/15, at 1:45 p.m. the		worked by nursing staff inclu		
	Riverview Care Ce	nter Nursing Staff Directly		TMA, LPN, and RN start and	l stop times.	
	Responsible for Re	esident Care posting was		Ongoing communications pe	rtaining to the	

TATE:	RS FOR MEDICARE					0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
		245251	B. WING _		01/2	23/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE	
RIVERVI	EW HOSPITAL & NUF	RSING HOME		323 SOUTH MINNESOTA CROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 356	holder attached to t area across from th was dated 1/21/15, and displayed the fe day shift (6:00 a.m. • One registered actual hours worke • Zero licensed p • Three nursing a 24 actual hours wo The nurse staff pos following three worl • Day shift - 6:00 • Evening shift - • Night shift-10:0 On 1/22/15, at 8:33 were scheduled boo RN-B confirmed the scheduled from 6 a p.m. until 6:30 a.m. On 1/23/15, at 8:17	n a clipboard in a clear plastic the wall in the main common ne nursing station. The posting and included a census of 21 ollowing information for the - 2:30 p.m.): nurse (RN) with a total of 8 d practical nurses (LPN) assistants (NA) with a total of rked sting form indicated the k shifts: a.m 2:30 p.m. 2:00 p.m 10:30 p.m. 0 p.m 6:30 a.m. a.m. RN-B stated the RNs th 12 hour and 8 hour shifts. e 12 hour shifts were m. until 6:30 p.m. or 6:00	F 3.	56 plan of corrections will staff meetings. -Daily staffing sheets a daily for review and file current regulations. Ra completed by the Direc weekly for 4 weeks of compliance then decre 6 months of consecuti Audit findings will be d meetings as well as qu improvment meetings.	are given to DON ed according to andom audits will be ctor of Nursing consecutive eased to monthly for ve compliance. liscussed at IDT uarterly quality	
	with the director of confirmed: • The 1/20/15, nu inaccurate as it did numbers and hours posting had not acc stop times of the tw worked 12 hour shi • The 1/21/15, nu inaccurate as it did numbers and hours posting had not acc	15 - 1/22/15, were reviewed nursing (DON) and she urse staff posting was not include RN-B in the RN worked. In addition, the curately reflected start and vo RNs (RN-C, RN-D) who fts. urse staff posting was not include RN-B in the RN worked. In addition, the curately reflected the start and vo RNs (DON, RN-C) who				

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		AND HUMAN SERVICES				FORM	03/05/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245251	B. WING			01/2	23/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	SING HOME			23 SOUTH MINNESOTA ROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 356	inaccurate as it did worked; the start ar licensed practical n hour shifts; LPN-A's p.m8:00 p.m.); an - 2:30 p.m. The Posting Direct policy dated 7/2013 post daily staffing in total number and ac	fts. urse staff posting was not include the DON's hours nd stop times of RN-B and urse (LPN)-B, who worked 12 is three hour shift (5:00 d NA-A's shift from 10:00 a.m. Care Daily Staffing Numbers a, indicated the facility would nformation which included the ctual hours worked for all nsed nursing staff directly	F 3	956			

Facility ID: 00470

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	MENT OF HEALTH			F529	57035	FORM	02/06/2015 APPROVED . 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU			PLE CONSTRUCTION 3 01 - NURSING HOME 01	(X3) DATE SU COMPLE	
		245251		B. WING		01/3	0/2015
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & N	URSING HOME		UTH MINN (STON, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI BE PRECEDED BY FULL NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	S		K 000	<u>, , , , , , , , , , , , , , , , , , , </u>		
	FIRE SAFETY						
	A Life Safety Code						
	Minnesota Departm marshal Division on						
	of this survey River	View Nursing Home	01 Main				
	Building was found requirements for pa		ne				
	Medicare/Medicaid 483.70(a), Life Safe		2000				
	edition of National F	ire Protection Assoc	viation				
	(NFPA) Standard 10 Chapter 19 Existing		(LSC),				
		riourn ouro.					
	RiverView Nursing H	Home is a 1-story bu	ilding				
	without a basement constructed at 2 diff		ninal				
	building was constru	ucted in 1974 and w	as				
	determined to be of In 2003 the south wi						
	additions to and rem	nodeling of the north					
	was determined to b construction. The bu		6 smoke				
	zones with fire barrie			10-11-11-11-11-11-11-11-11-11-11-11-11-1			
	The facility has a fire			and the second			
	detection throughout the common spaces						
	monitored for autom						
	notification and is in	stalled in accordanc	e with				
	NFPA 72 "The Natio edition). Hazardous						
	detection that is on t	he fire alarm systen	ו in				
	accordance with the (2007 edition). The f		2				
	department notificati						
	created in 2003 have	e single station smo	ke	2000 March 1990 March 1			
	detectors installed in						
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESE	NTATIVE'S SIGN		TITLE		(X6) DATE

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.

		AND HUMAN SERV & MEDICAID SERV				FOR	l: 02/06/201 MAPPROVE D. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		. ,	LE CONSTRUCTION 01 - NURSING HOME 01	(X3) DATE : COMPL	SURVEY
		245251		B. WING		01/	30/2015
	ROVIDER OR SUPPLIER	<u> </u>			TATE, ZIP CODE		
RIVERVI	EW HOSPITAL & N	URSING HOME		UTH MINN (STON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI BE PRECEDED BY FULL NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	alarm at the nurse's side of the rooms. T sprinkler system ins NFPA 13 Standard t Sprinkler Systems ( The facility has a ca census of 22 at the The facility was surv 1974 portion of the used for healthcare.	re Code (2007 editions s station and on the of The building has an a stalled in accordance for Installation of Aut 1999 edition). apacity of 24 beds ar time of the survey. veyed as one buildin building is not currer 42 CFR, Subpart 48	orridor automatic e with omatic nd had a g. The ntly being	Κ 000	DEFICIENCY		
RM CMS-2	567(02-99) Previous Vers	sions Obsolete			O4BD21	If continuation	sheet Page 2 c

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Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered February 6, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5251036

Dear Mr. Mielke:

The above facility was surveyed on January 21, 2015 through January 23, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This

column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Lyla Burkman at (218) 308-2104 or email: lyla.burkman@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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 Minnesota Department of Health mark.meath@state.mn.us

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

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Minneso	ta Department of He	alth			1 01 101	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00470	B. WING		01/2	3/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	ISING HOME	TH MINNESC TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of	nether a violation has been compliance with all				
	number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	e rule provided at the tag ule number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
Minnesota D	Department's staff the following licensi corrections are com on the bottom of the with "Laboratory Dir	TS: & 23, 2015, surveyors of this visited the above provider and ing orders were issued. When inpleted, please sign and date e first page in the line marked rector's or Provider/Supplier gnature." Make a copy of		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. to	
		ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

Electronically Signed

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If continuation sheet 1 of 14

TATEMENT OF DEFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		SURVEY LETED
		00470	B. WING		01/2	3/2015
AME OF PROVIDER		SING HOME 323 SOL	DDRESS, CITY, JTH MINNES STON, MN 5			
PREFIX (EAC	CH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLE DATE
2 000 Continu	ed From pa	ge 1	2 000			
original Minneso 705 Fift 56601-2	to the addre ota Departm h Street NW 2933	r records and return the ss below: ent of Health , Suite A, Bemidji, MN Init Supervisor		The assigned tag number app far left column entitled "ID Pr The state statute/rule number corresponding text of the stat out of compliance is listed in f "Summary Statement of Defic column and replaces the "To portion of the correction order column also includes the fin- are in violation of the state stat statement, "This Rule is not m evidenced by." Following the findings are the Suggested M Correction and the Time Peric Correction. PLEASE DISREGARD THE F THE FOURTH COLUMN WH STATES, "PROVIDER'S PLA CORRECTION." THIS APPLI FEDERAL DEFICIENCIES O WILL APPEAR ON EACH PA THERE IS NO REQUIREMEN SUBMIT A PLAN OF CORRECTIONS OF MINNESO STATUTES/RULES.	efix Tag." r and the e statute/rule the ciencies" Comply" r. This dings which atute after the net as e surveyors lethod of od For HEADING OF IICH N OF ES TO NLY. THIS GE. NT TO CCTION FOR	
	te Statute 14 ed disorder t	4.6503 Alzheimer's disease rain	2 302			4/10/15
(a) If a r Alzheim disease	DER TRAINI Statute 144. nursing facili per's or related d	6503 ty serves persons with isorders, whether in a				
		ral unit, the facility's direct				

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	
		00470	B. WING		01/2	3/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUI	RSING HOME	TH MINNESC STON, MN 56			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)		COMPLET DATE
2 302	Continued From pa	age 2	2 302			
	care staff and their supervisc care.	ors must be trained in dementia	L			
	related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shal written or electronic training program, the trained, the frequent topics covered.	of Alzheimer's disease and activities of daily living; with challenging behaviors;				
	by: Based on interview facility failed to pro training for 2 of 4 n NA-B) and for 1 of provided direct car facility failed to pro information regardi program. This had residents and their facility. Findings include: NA-A was hired on	2 and document review, the vide the required Alzheimer's oursing assistants (NA-A, 1 registered nurse (RN-A) who e services. In addition, the vide consumers with written ing the Alzheimer's training the potential to affect all 21 families who resided in the 7/7/14, and the employee ence of having received the 's training.		-Staff identified in statement of deficiencies have been educated importance of completing deme orientation and passing of test w weeks of education. A notice to consumers regarding details of program will be posted on facility pending authorization of market department. -Personnel files of all staff will be and staff without documentation dementia orientation in persone given two weeks to complete an dementia orientation test. New s complete departmental dementi orientation with a deadline of two given to complete and pass test	ntia vithin two our traning y website ing e reviewed of l file will be d pass staff must a o weeks	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00470	B. WING		01/2	3/2015
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
IVERVI	EW HOSPITAL & NUF		TH MINNESC TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLE DATE
2 302	Continued From pa	ge 3	2 302			
	record lacked evide required Alzheimer' RN-A was hired on record lacked evide required Alzheimer' On 1/22/15, at 1:20 (DON) confirmed N completed their Alz should have. On 1/23/15, at 8:49 confirmed they curr information to their details of their Alzhe the facility had train trained and the bas covered.	12/15/14, and the employee ence of having received the		-Yearly hand in hand traini required for all current and Mulitiple sessions will be of module of the training. Star required to complete this t of their yearly inservice red Staff were educated on our ongoing dementia training staff meeting. -Audits for dementia training will be completed by Direc monthly for 3 months of co compliance then decrease for 3 quarters of consecuti Audit findings will be discu meetings as well as quarter improvment meetings.	d future staff. offered for each off will be raining as part quirements. In plan to provide at the 2/3/15 Ing compliance tor of Nursing onsecutive ed to quarterly ve compliance. Issed at IDT	
	The director of nurs implement policies required Alzheimer' requirements. The assurance committe audits to ensure co	quality assessment and ee could perform random mpliance.				
	days	R CORRECTION: Twenty (21)				
2 570	MN Rule 4658.0409 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570			4/10/15

	ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:		i:	(X3) DATE SURVEY COMPLETED		
		00470	B. WING		01/2:	3/2015
RIVERVIEV	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	W HOSPITAL & NUF	RSING HOME	TH MINNES TON, MN 5			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLET DATE
2 570 C	Continued From pa	ige 4	2 570			
c ir p fr c a p g c t t	care must be review nterdisciplinary tea ohysician, a registe or the resident, and disciplines as deter and, to the extent poarticipation of the guardian or chosen quarterly and within he comprehensive	A comprehensive plan of wed and revised by an im that includes the attending ored nurse with responsibility d other appropriate staff in mined by the resident's needs, practicable, with the resident, the resident's legal representative at least n seven days of the revision of resident assessment required subpart 3, item B.				
b E fr F F S P F U S a tt C (	by: Based on interview acility failed to revi residents (R9) to in antipsychotic medic Findings include: R9's physician's ord Seroquel 25 milligra bychosis/paranoia R9's care plan revie use of an antianxie Seroquel was not a any behavioral sym he Seroquel. On 1/22/15, at 11:5 DON) stated they	der dated 12/1/14, read ams (mg) at bedtime for		-For the resident in question, the ca was revised on 1/27/15 to include th administration of Seroquel. Care pla updated for monitoring of intervention well on 1/27/15. -All care plans are reviewed quarter re-written annually. Care plans are a updated on an ongoing basis as cha arise with their needs and care leve After any new psychotropic medical started, the charge nurse will updat care plan and implement clinical monitoring. All residents receiving a psychotropic medication will have a of care in place that addresses this Care plans are updated with intervent that are individualized for that reside -Follow-up of any new psychotropic medication will be checked by DON or MDS Coordinator the following business day to ensure care plans are	ne an was ons as rly and also anges els. tion is e the a plan area. entions ent.	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00470	B. WING		01/2	3/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUP		ITH MINNES STON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 5	2 570			
	the target behavior plans were updated to update more offer The Behavior Moni	toring policy reviewed 3/97,		reviewed and new policy re maintaining care plan com implemented.Improvemen policy on behavior monitor adressed at staff meeting. -Care plans for residents r psychotropic medication w	pliance will be ts to current ing will be eceiving ill be audited by	
	the resident's Plan updated with any c approach, resident the addition of a ps individual resident	viors were also documented ir of Care. This information was hange in the behavior, staff's 's ability to be redirected and ychotropic medication. Identify "target" behaviors. Add goals, and interventions to the care plan.	,	the Director of Nursing mo months of consecutive cor decreased to quarterly for consecutive compliance. <i>A</i> be discussed at IDT meeti quarterly quality improvme	npliance then 3 quarters of Audit findings will ngs as well as	
	The director of nurs implement policies care plan revisions training for all nurs timeliness of care p assessment and as	THOD FOR CORRECTION: sing (DON) could develop and and procedures related to . The DON could provide ing staff related to the blan revisions. The quality ssurance committee could udits to ensure compliance.				
	TIME PERIOD FOI days	R CORRECTION: Twenty (21	)			
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426			3/2/15
	maintain a compre- infection control pro- current tuberculosis issued by the Unite	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines of States Centers for Disease ntion (CDC), Division of				

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION (X:	3) DATE SURVEY COMPLETED
		00470	B. WING		01/23/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
RIVERVI	EW HOSPITAL & NUI	RSING HOME	TH MINNES TON, MN 50		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
21426	Continued From pa	age 6	21426		
	This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding impleme	ality Weekly Report (MMWR). t include a tuberculosis an that covers all paid and contractors, students, inteers. The Department of e technical assistance ntation of the guidelines. ance with this subdivision must he nursing home.			
	by: Based on interview facility failed to ens NA-D) received a tr (TST) prior to reside potential to affect a the facility. Findings include: NA-C's hire date w (TST) administration received step one of test was read on 10 The facility lacked second step of the NA-D's hire date w administration form one of the TST on 5/23/14, with a neg documentation tha TST had been com On 1/22/15, at 11:5	ent is not met as evidenced y and document review, the sure 2 of 6 employees (NA-C, wo-step tuberculin skin test lent contact. This had the all 21 residents who resided in as 11/3/14. NA-C's mantoux on form indicated NA-C of the TST on 10/23/14. This 0/26/14, with a negative result. documentation that NA-C's TST had been completed. as 6/2/2014. NA-D's TST n indicated NA-D received step 5/21/14. This test was read on pative result. The facility lacked t NA-D's second step of the npleted. 57 a.m. the administrator stated red she had worked		-All employee personnel files were at on 1/22/15 for TB testing compliance Staff without sufficient TB testing documentation must complete a bloc draw TB test before returning to work -Current staff working in our facility a compliant with TB testing requirement per personnel file audit. -Policy updates have been made on organizational TB testing. New employ will no longer be doing a 2 step Mant skin test upon hire, they will be doing one time blood test. This will be required before the employee can attend New Employee Orientation. If employees a hired with prior mantoux testing documented, we will work with them case by case basis in accordance with MDH guidelines. -Audit of TB testing documentation for new Care Center employees will be of	d c. re hts oyees oux a ired are on a th or

STATE FORM

	ota Department of He	alth (X1) PROVIDER/SUPPLIER/CLIA		-E CONSTRUCTION	(X3) DATE	
				:	COMPLETED	
		00470	B. WING		01/2	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	RSING HOME	TH MINNESC TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21426	Continued From pa	ige 7	21426			
	somewhere else. T according to facility provided the facility had received a neg last year. The adm currently working at not provided the face nor had she complet TST. On 1/22/15, at 12:1 confirmed NA-C cu and that she had not the TST as directed On 1/22/15, at 1:36 preventionist (IP) si that they had not be achieve getting the employees. The IP should have had th completed within the the reading of their On 1/22/15, the hun confirmed NA-C an two-step TST comp The Employee Hea policy dated 1/2011 workers at the facili TST completed. If second test should to three weeks late SUGGESTED MET The director of nursi develop and impler related to the requin The quality assess	he administrator confirmed policy NA-D should have with documentation that she ative resulting TST within the inistrator verified NA-D is t the facility and that she had cility with this documentation, eted the second step of the 7 p.m. the administrator rrently worked at the facility of received the second step of d by facility policy. p.m. the infection tated the facility recognized een able to consistently TST completed on their new Confirmed NA-C and NA-D eir second steps of the TST is one to three weeks following first step. man resource generalist d NA-D did not have their oleted. Ith Tuberculosis Program , indicated all healthcare ity were to have a two-step the initial test was positive, the have been administered one r.		before completion of New E Orientation dates. Audits we months of consecutive com decreased to yearly by Dire and reported at quarterly qu improvement meetings.	ill occur for 6 Ipliance then Ictor of Nursing	

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		00470	B. WING		01/2	3/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	RSING HOME	TH MINNESO TON, MN 56 <sup>-</sup>			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET DATE
21426	Continued From pa	ge 8	21426			
	TIME PERIOD FOR days	R CORRECTION: Twenty (21)				
21535	MN Rule4658.1315 Drug Usage; Gene	Subp.1 ABCD Unnecessary al	21535			4/10/15
	must be free from u unnecessary drug i A. in excessive	al. A resident's drug regimen innecessary drugs. An s any drug when used: dose, including duplicate drug				
	D. in the prese	e duration; quate indications for its use; or nce of adverse consequences lose should be reduced or				
	In addition to the d part 4658.1310, th with provisions in th Code of Federal Re 483.25 (1) found in	rug regimen review required in e nursing home must comply ne Interpretive Guidelines for egulations, title 42, section Appendix P of the State				
	Long-Term Care Fa Department of Hea Health Care Finance This standard is inc	, Guidance to Surveyors for acilities, published by the lth and Human Services, ing Administration, April 1992. corporated by reference. It is the Minitex interlibrary loan				
		te Law Library. It is not				
	by:	ent is not met as evidenced on, interview and document		-The resident involved in this situ	ation had	
	review, the facility f (R9) had adequate	ailed to ensure 1 of 3 residents indications warranting the use (Seroquel) medication.		care plan reviewed by staff and c was updated to include target beh and appropriate interventions on -Target behaviors are identified u	naviors 1/27/15.	

NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITV, STATE, ZIP CODE           323 SOUTH MINNESOTA CROOKSTON, MN 56716         323 SOUTH MINNESOTA CROOKSTON, MN 56716           (4) ID PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         0           21535         Continued From page 9         21535           Findings include:         21535           89's admission Minimum Data Set (MDS) dated 11/12/14, indicated R9 had severe cognitive impairment. The MDS did not include any behavior symptoms noted for R9. The Cognitive care Area Assessment (CAA) dated 11/12/14, indicated R9 did get anxious a little bit, but was easily relieved. Very pleasant and sociable. A Psychotropic CAA should have completed but was lacking.         21535           On 1/22/15, at 7:06 a.m. R9 was observed in the day room in the recliner. R9 was listening and watching a musical video on the TV and was enjoying the singing.         Nadition, care plans will indicated non-pharmacological interventions. Facility is registered to participate in the National Nursing Home Quality Care Collaborative through Stratis health to identify the best practices for reducing antipsychotic medication and identifying the best practices for reducing antipsychotic medication and identifying the best practices for reducing antipsychotic medication and identifying appropriate indications for use tor all behavioral modification interventions. Facility is registered to participate in the National Nursing Home Quality Care collaborative through Stratis health to identify the best practices for reducing antipsychotic medication and identifying appropriate indications for use tor all be	STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
BIVERVIEW HOSPITAL & NURSING HOME         323 SOUTH MINNESOTA CROOKSTON, MN 56716           YM ID PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH ODRECTIVE ACTION SHOULD BE (EACH ODRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)         OP PREFIX TAG         PROVIDER'S PLAN OF CORRECTION (EACH ODRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)         OP PREFIX TAG           21535         Continued From page 9         21535         atmission and revised quarterly and PRN as the residents needs change. New or worsening behaviors will be discussed weekly by IDT meetings. Indications for uses of an antipsychotic will be discussed weekly by IDT meetings. Indications for uses of an antipsychotic will be discussed weekly by IDT.         Correction worsening behaviors will be discussed weekly and as needed by IDT.           On 1/22/15, at 7:06 a.m. R9 was observed in the day room in the recliner. R9 was listening and watching a musical video on the TV and was enjoying the singing.         No 11/22/15, at 7:36 a.m. R9 was ambulating in the hallway with her walker. R9 was conversational with the surveyor.         No 11/22/15, at 7:36 a.m. R9 was ambulating in the hallway with her walker. R9 was conversational with the surveyor.         No 11/22/15, at 8:35 a.m. R9 was ambulating in the hallway with her walker. R9 was conversational with the surveyor.         No 11/22/15, at 8:35 a.m. R9 was ambulating in the hallway with her walker. R9 was conversational with the surveyor.         No 11/22/15, at 7:06 a.m. R9 was ambulating in the hallway with her walker. R9 was conversational with the surveyor.         No 11/22/15, at 7:06 a.m. R9 was ambulating in the hallway with her walker. R9 was conversational with t			00470	B. WING		01/23/2015	
RIVERVIEW HOSPITAL & NURSING HOME         CROOKSTON, MN 56716           (X4) ID 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 DEFICIENCY)         (PA) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY)           21535         Continued From page 9         21535         (PA) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY)         (PA) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY)           21535         Continued From page 9         21535           Findings include:         admission and revised quarterly and PRN as the residents needs change. New or vorsening behaviors will be discussed weekly by IDT meetings. Indications for use of an antipsychotic will be identified prior to initiation of add medication by interdisciplinary team. Changes in resident behavior will be addressed weekly and as needed by IDT.           On 1/22/15, at 7:06 a.m. R9 was observed in the day room in the recliner. R9 was listening and watching a musical video on the TV and was enjoying the singing.         On 1/22/15, at 8:35 a.m. R9 was ambulating in the hallway with her walker. R9 was conversational with the surveyor.         Sum Attribute Attribute Attribute Attribute Attribute Xanax (anti-anxiety) medication 2.5 mg at bedtime and three times a day as needed (PRN).         Pa's admission orders dated 11/5/14, indicated R9 had been doing okay but recently had become more aggressive and had tired to elope several times and it was decided she needed to be placed in a locked memory care unit.         - Policy has been reviewed and will be updatet to reflect these changes and numer sing staff will be	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
CHOORSTON, NM 56716CHOORSTON, NM 56716PHERK TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MILLY BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)D PHERK TAGPROVIDER'S PLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOULD BE CROSSRECTENCE DT OF MEAPROPRIATE DEFICIENCY)D D (EACH ORRECTIVE ACTION SHOULD BE (EACH ORRECTIVE ACTION SHOULD BE CROSSRECTENCE DT OF MEAPROPRIATE DEFICIENCY)D D (EACH ORRECTIVE ACTION SHOULD BE CROSSRECTER ACTION SHOULD BE CROSSRECTER ACTION SHOULD BE DEFICIENCY)D D (EACH ORRECTIVE ACTION SHOULD BE CROSSRECTER ACTION SHOULD BE CROSSRECTER ACTION SHOULD BE DEFICIENCY)D D D CACH ORRECTIVE ACTION SHOULD BE CROSSRECTER ACTION SHOULD BE CROSSRECTER ACTION SHOULD BE CROSSRECTER ACTION SHOULD BE ACTION SHOULD BE ACTION SHOULD BE CROSSRECTER ACTION SHOULD BE ACTION STATEMENT, AND ACTION SHOULD BE ACTION SHOULD BE ACTION STATEMENT, AND ACTION STATEMENT, AND ACTION STATEMENT, AND ACTION ACTION ACTION STATEMENT, AND ACTION STATEMENT, AND ACTION ACTI	RIVERVI	FW HOSPITAL & NUI	RSING HOME				
PHÉFIX TAG         (EACH DEFICIENCY NUIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         PRÉFIX TAG         (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         construint           21535         Continued From page 9         21535         admission and revised quarterly and PRN as the residents needs change. New or worsening behaviors will be discussed use of an antipsychotic will be discussed weekly by IDT meetings. Indications for use of an antipsychotic will be discussed weekly by IDT meetings. Indication by interdisciplinary team. Changes in resident behavior will be datoressed weekly and as needed by IDT. -Care Plans will be tailored to meet the individualized needs of the resident. This plan of care will provide clear interventions to staff on how to best care for residents and their needs. Care Plans will indication interventions to staff on how to best care for residents and their needs. Care Plans will indication interventions to staff on how to best care for residents and their needs. Care Plans will indication on the result on participate in the National Nursing Home Coultify Care Collaborative through Stratis health to identify the best practices for reducing aptropychotic will be tailored to medication interventions. To addition, care plans will indicate on-pharmacological interventions to try prior to medication interventions to try prior to medication interventions to try prior to medication interventions to revice for reducing aptipsychotic will be set practices for reducing aptipsychotic medication and identifying the best interventions to provide residents with least restrictive environment possible.         Philore head and their the placed in a locked memory care unit.			CROOKS	TON, MN 5	6716		
<ul> <li>Findings include:</li> <li>Findings include:</li> <li>R9's admission Minimum Data Set (MDS) dated 11/12/14, included R9 had severe cognitive impairment. The MDS did not include any behavior symptoms noted for R9. The Cognitive Care Area Assessment (CAA) dated 11/12/14, indicated R9 did get anxious a little bit, but was easily relieved. Very pleasant and sociable. A Psychotropic CAA should have completed but was lacking.</li> <li>On 1/22/15, at 7:06 a.m. R9 was observed in the day room in the recliner. R9 was listening and watching a musical video on the TV and was enjoying the singing.</li> <li>On 1/23/15, at 8:35 a.m. R9 was ambulating in the hallway with her walker. R9 was conversational with the surveyor.</li> <li>R9's admission orders dated 11/5/14, included Xanax (anti-anxiety) medication 0.25 mg at bedtime and three times a day as needed (PRN).</li> <li>The physician's progress note dated 11/5/14, included Xanax (anti-anxiety) medication 0.25 mg at bedtime and three times a day as needed (PRN).</li> <li>The physician's progress note dated 11/5/14, included Xanax (anti-anxiety) medication 0.25 mg at bedtime and three times a day as needed (PRN).</li> <li>The physician's progress note dated 11/5/14, included Xanax (anti-anxiety) medication 0.25 mg at bedtime and three times a day as needed (PRN).</li> <li>The physician's progress note dated 11/5/14, indicated R9 had been doing okay but recently had become more aggressive and had tried to elope several times and it was decided she needed to be placed in a locked memory care unit.</li> </ul>	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API	IOULD BE	(X5) COMPLET DATE
<ul> <li>as the residents needs change. New or worsening behaviors will be discussed weekly by IDT meetings. Indications for use of an antipsychotic will be identified prior to initiation of said medication by interdisciplinary team. Changes in resident behavior will be addressed weekly by IDT meetings. Indication by interdisciplinary team. Changes in resident behavior will be addressed weekly and as needed by IDT.</li> <li>On 1/22/15, at 7:06 a.m. R9 was observed in the day room in the recliner. R9 was listening and watching a musical video on the TV and was enjoying the singing.</li> <li>On 1/23/15, at 8:35 a.m. R9 was ambulating in the hallway with her walker. R9 was conversational with the surveyor.</li> <li>R9's admission orders dated 11/5/14, included Xanax (anti-anxiety) medication 0.25 mg at bedtime and three times a day as needed (PRN).</li> <li>The physician's progress note dated 11/5/14, included Xanax (anti-anxiety) medication 0.25 mg at bedtime and three times a day as needed (PRN).</li> <li>The physician's progress note dated 11/5/14, included Xanax (anti-anxiety) medication 0.25 mg at bedtime and three times a day as needed (PRN).</li> <li>The physician's progress note dated 11/5/14, included identifying the best interventions to provide residents with least restrictive environment possible.</li> <li>Policy has been reviewed and will be updated to reflect these changes and nursing staff will be re-educated on identifying appropriate indication for use for all behavioral modification interventions. Audits will be completed by</li> </ul>	21535	Continued From pa	age 9	21535			
On 11/29/14, registered nurse (RN)-C sent a fax to R9's primary physician. The fax read: "for your information. Resident does not sleep well at night. Had paranoid behaviors at times. Came from room after being checked on routine rounds andDirector of nursing monthly for 3 months of consecutive compliance then decreased to quarterly for 3 quarters of consecutive compliance. Audit findings will be discussed at IDT meetings as well as quarterly quality improvment meetings.	21535	Findings include: R9's admission Mir 11/12/14, indicated impairment. The M behavior symptoms Care Area Assess indicated R9 did ge easily relieved. Ver Psychotropic CAA was lacking. On 1/22/15, at 7:06 day room in the red watching a musical enjoying the singing On 1/23/15, at 8:35 the hallway with he conversational with R9's admission ord Xanax (anti-anxiety bedtime and three The physician's pro- indicated R9 had b had become more elope several times needed to be place unit. On 11/29/14, regist to R9's primary phy information. Reside Had paranoid beha	himum Data Set (MDS) dated R9 had severe cognitive IDS did not include any s noted for R9. The Cognitive nent (CAA) dated 11/12/14, et anxious a little bit, but was y pleasant and sociable. A should have completed but 6 a.m. R9 was observed in the cliner. R9 was listening and I video on the TV and was g. 6 a.m. R9 was ambulating in r walker. R9 was n the surveyor. ders dated 11/5/14, included () medication 0.25 mg at times a day as needed (PRN). ogress note dated 11/5/14, een doing okay but recently aggressive and had tried to s and it was decided she ed in a locked memory care tered nurse (RN)-C sent a fax visician. The fax read: "for your ent does not sleep well at night. aviors at times. Came from	21535	<ul> <li>as the residents needs change worsening behaviors will be disweekly by IDT meetings. Indications of an antipsychotic will be prior to initiation of said medication of said medications of an antipsychotic will be prior to initiation of said medications of said medications will be addressed were needed by IDT.</li> <li>Care Plans will be tailored to resident of and their needs. Care Plans will be their needs. Care Plans will be their needs. Care Plans will be their needs. Care Plans will valid indications of use for all predications. In addition, care predications. In addition, care predications. In addition, care predications to try prior to medicate non-pharmacological intervention. Facility is register participate in the National Nurse Quality Care Collaborative through to identify the best practive through the best intervention residents with least restrictive of possible.</li> <li>Policy has been reviewed and updated to reflect these changen nursing staff will be re-educate identifying appropriate indication interventions. Audits will be conditioned to reflect these changen nursing staff will be re-educate identifying appropriate indication interventions. Audits will be conditioned to reflect these changen nursing staff will be re-educated identifying appropriate indication interventions. Audits will be conditioned to reflect these changen nursing staff will be re-educated identifying appropriate indication interventions. Audits will be conditioned to reflect these changen nursing staff will be readicated to reflect the se changen nursing staff will be readicated to reflect the se changen nursing staff will be readicated to reflect the se changen nursing staff will be readicated to reflect the se changen nursing staff will be readicated to reflect the se changen nursing staff will be readicated to reflect the se changen nursing staff will be readicated to reflect the se changen nursing staff will be readicated to reflect the se changen nursing staff will be readicated to reflect the se changen nursi</li></ul>	A. New or scussed ations for identified ation by s in resident ekly and as meet the ident. This nterventions residents ill include by chotropic blans will dication ed to sing Home bugh Stratis ices for tion and ns to provide environment d will be es and d on ons for use mpleted by 3 months n arters of findings will as well as	

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00470	B. WING		01/	23/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NU	RSING HOME	JTH MINNESO STON, MN 567			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 10	21535			
	is a new statement advise, Thank You	for the resident. Please				
	Seroquel 25 mg at behaviors. However resident's condition symptoms could be non-pharmacologic	cal interventions versus ise of an antipsychotic				
	records (MAR) dat January 2015, R9 d during the months received 1 PRN do	edication administration ed November 2014, through did not receive any Xanax PRI of November or January. R9 use of Xanax on 12/22/14, due and irritation, with the results				
	use of an antianxie Seroquel was not a	ewed 11/20/14, addressed the ety medication. However, the addressed on the care plan or optoms related to the use of				
	indicated R9 was r month ago. After a started having a lo not behaving appro	bgress note dated 12/17/14, ecently admitted about a few days of being admitted R9 t of behavioral issues. R9 was opriately and was having tion and was a little difficult to ff.				
	(DON) stated RN-0 11/29/14, as a FYI inform the physicia think RN-C was loc	4 a.m. the director of nursing C had faxed the physician on (for information only) just to n. The DON stated she did no oking for a medication order. 9 was having paranoid	t			

	IT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
		00470	B. WING		01/	23/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUI	RSING HOME	ITH MINNESOT STON, MN 567			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21535	Continued From pa	age 11	21535			
		pple going into her room. The ranoid behaviors would be nurses notes.				
		ecured doors				
	come out of her roo stealing all of her s able to state what p stated she would h closet and in the dr also hide hangers take them. RN-B s they had taken all o dresser drawer. RN	7 a.m. RN-B stated R9 would om and stated people were tuff. RN-B stated R9 was not beople were stealing. RN-B ide her wet clothes in the rawers. RN-B stated R9 would in the drawer so no one would tated R9 had stated to her, see of this, referring to the top N-B then found out from the II ups were gone from the top ere added.				
	find a policy related The DON provided which read, "target shift." The DON sta the "target behavio yet, and she wante determine how the	OON stated she was unable to d to antipsychotic medications. a behavior monitoring policy behaviors documented every ated they had not determined r" for the use of the Seroquel d to talk with RN-B to y should word it. The DON rel was not on the care plan or				
	every Tuesday. NA doing R9's bath in would get up at 6:0	stated she gave R9 a bath A-E stated the night staff was the early morning when she 00 a.m. NA-E stated R9 would est of the day. NA-E stated R9				

ATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	00470	B. WING		01/	23/2015		
ME OF PROVIDER OR SUPPL		DDRESS, CITY, S	TATE. ZIP CODE	01/23/			
VERVIEW HOSPITAL &		TH MINNESO	ТА				
	CROOK	STON, MN 567					
REFIX (EACH DEFICI	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE		
21535 Continued Fron	n page 12	21535					
she now gives I goes well. NA-E would wash her and she accept heard R9 being	change her clothing. NA-E stated R9 her bath after breakfast and it stated she would tell R9 she clothes and get them back to her ed that. NA-E stated she had not paranoid of different things. NA-E think that people are taking her						
stated a diagno diagnosis to wa CP stated R9 h week prior to he would also wan	e consulting pharmacist (CP) sis of psychosis would be a valid rrant the use of the Seroquel. The ad only been on the Seroquel for a er review. The CP stated she t to know what the behavior R9 ould constitute paranoid behavior	a					
interviewed via the phrase "I wi stated R9 would room at all. She she thought per when they saw see R9 getting was huffing and physician did no wanted the staf was a necessity irritated and ney then she would stated, "I would tried the Xanax been on a med R9 had been a	's family member (FM)-A was phone. FM-A stated R9 had said Il kill myself" if she got mad. FM-/ d be upset if staff came into her did not like people in her room as ople were stealing. FM-A stated the physician on 11/5/14, he could more and more agitated, and she puffing. FM-A stated the of want to order a medication, he to observe R9 more and see if fr. FM-A stated R9 would seem gative when she came to visit and try and change the topic. FM-A have thought they would have first." FM-A stated R9 had never cation for paranoia. FM-A stated private person who does not want with family members.	5					
	3:54 a.m. the DON stated during suspicious about other residents.						

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00470 B. WING			01/	23/2015
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
IVERVI	EW HOSPITAL & NUI	RSING HOME	TH MINNESO STON, MN 567			
(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) COMPLET DATE
21535	Continued From pa	age 13	21535			
	intent was not to ge medication. The Do the Seroquel until t	fore, the Seroquel was not				
	read problem beha the resident's Plan updated with any c approach, resident the addition of a ps individual resident	itoring policy reviewed 3/97, wiors were also documented in of Care. This information was hange in the behavior, staff's 's ability to be redirected and sychotropic medication. Identify "target" behaviors. Add , goals, and interventions to the care plan.	,			
	The director of nurse pharmacist could p staff related to anti- addition, the DON a could develop and procedures related medications. The c	THOD FOR CORRECTION: sing (DON) along with the provide training for all nursing psychotic medications. In along with the pharmacist implement policies and to the use of antipsychotic quality assessment and tee could perform random ompliance.				
	TIME PERIOD FOI days	R CORRECTION: Twenty (21	)			