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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: O4BD

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

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

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

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

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/12/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **24** (L18)

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	24			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 03/18/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 03/18/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/24/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/11/2015
(L33)

DETERMINATION APPROVAL

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245251	A. Building B. Wing	3/12/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **03/10/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/10/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **03/10/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** LB/mm	**Date:** 03/18/2015	**Signature of Surveyor:** 28035	**Date:** 03/12/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 1/23/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: O4BD

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Facility ID: 00470

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(L1) **245251**
2.STATE VENDOR OR MEDICAID NO.
(L2) **861347800**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/23/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **24** (L18)

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	24			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Jane Aandal, HFE NEII 03/05/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 03/09/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
08/01/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/11/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, 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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

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

Sincerely,

Mark Meath

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

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

5251s15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	01/23/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		3/10/15

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

Electronically 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	01/23/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan for 1 of 3 residents (R9) to include the use of an antipsychotic medication (Seroquel). Findings include: R9's physician's order dated 12/1/14, read Seroquel 25 milligrams (mg) at bedtime for psychosis/paranoia. R9's care plan reviewed 11/20/14, addressed the use of an antianxiety medication. However, the Seroquel was not addressed on the care plan or any behavioral symptoms related to the use of the Seroquel. On 1/22/15, at 11:55 a.m. the director of nursing (DON) stated they had not determined the "target behavior" for the use of the Seroquel yet, and she wanted to talk with registered nurse (RN)-B to determine how they should word it. The DON verified the Seroquel was not on the care plan or the target behavior. The DON stated the care plans were updated quarterly and stated they try to update more often if able. The Behavior Monitoring policy reviewed 3/97, read problem behaviors were also documented in the resident's Plan of Care. This information was updated with any change in the behavior, staff's approach, resident's ability to be redirected and the addition of a psychotropic medication. Identify individual resident "target" behaviors. Add	F 280	-For the resident in question, the care plan was revised on 1/27/15 to include the administration of Seroquel. Care plan was updated for monitoring of interventions as well on 1/27/15. Survey results and plans for improvement were discussed at 2/3/15 staff meeting. -All care plans are reviewed quarterly and re-written annually. Care plans are also updated on an ongoing basis as changes arise with their needs and care levels. After any new psychotropic medication is started, the charge nurse will update the care plan and implement clinical monitoring. All residents receiving a psychotropic medication will have a plan of care in place that addresses this area. Resident target behaviors are identified with assessment upon admission and included in initial care plan for monitoring. When new or worsening behaviors are identified, care plan is updated to reflect these changes so staff can implement appropriate interventions.Care plans are updated with interventions that are individualized for that resident. -Follow-up of any new psychotropic medication will be checked by DON, RCC, or MDS Coordinator the following business day to ensure care plans are updated correctly. Policy and procedures related Behavior monitoring have been reviewed and new policy related to maintaining care plan compliance will be implemented. Ongoing communications pertaining to the plan of corrections will	

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	245251	A. BUILDING _____ B. WING _____	01/23/2015

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F 280	Continued From page 2 behavior concerns, goals, and interventions to the individual resident care plan.	F 280	occur at monthly staff meetings. -Care plans for residents receiving psychotropic medication will be audited by the Director 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.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		3/10/15

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F 329	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R9) had adequate indications warranting the use of an anti-psychotic (Seroquel) medication. Findings include: R9'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. 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 1/23/15, at 8:35 a.m. R9 was ambulating in the hallway with her walker. R9 was conversational with the surveyor. 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). 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.	F 329	-The resident involved in this situation had care plan reviewed by staff and care plan was updated to include target behaviors and appropriate interventions on 1/27/15. Survey results and plans for improvement were discussed at 2/3/15 staff meeting. -Target behaviors are identified upon admission and revised quarterly and PRN 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 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. Resident target behaviors are identified with assessment upon admission and included in initial care plan for monitoring. When new or worsening behaviors are identified, care plan is updated to reflect these changes so staff can implement appropriate interventions. Care Plans will include valid indications of use for all psychotropic medications. In addition, care plans will indicate non-pharmacological interventions to try prior to medication intervention. Facility is registered to participate in the National Nursing Home Quality Care Collaborative through Stratis health to identify the best	

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F 329	Continued From page 4 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 and wanted to know if she was safe. Stated, "I don't like it, "If I am not safe I will just kill myself." This is a new statement for the resident. Please advise, Thank You." On 12/1/14, the primary physician ordered Seroquel 25 mg at bedtime for paranoid behaviors. However, an assessment of the resident's condition to determine if behavioral symptoms could be modified with non-pharmacological interventions versus implementing the use of an antipsychotic medication was lacking. According to the medication administration records (MAR) dated November 2014, through January 2015, R9 did not receive any Xanax PRN during the months of November or January. R9 received 1 PRN dose of Xanax on 12/22/14, due to increased crying and irritation, with the results being "helped." The care plan reviewed 11/20/14, addressed the use of an antianxiety medication. However, the Seroquel was not addressed on the care plan or any behavioral symptoms related to the use of the Seroquel. The physician's progress note dated 12/17/14, indicated R9 was recently admitted about a month ago. After a few days of being admitted R9 started having a lot of behavioral issues. R9 was not behaving appropriately and was having	F 329	practices for reducing antipsychotic medication and identifying the best interventions to provide residents with least restrictive environment possible. Ongoing communications pertaining to the plan of corrections will occur at monthly staff meetings. - Policy has been reviewed and will be updated to reflect these changes and nursing staff will be re-educated on identifying appropriate indications for use for all behavioral modification interventions. Audits will be completed by Director 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.	

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F 329	Continued From page 5	F 329		

paranoia and agitation and was a little difficult to manage for the staff.

On 1/22/15, at 8:54 a.m. the director of nursing (DON) stated RN-C had faxed the physician on 11/29/14, as a FYI (for information only) just to inform the physician. The DON stated she did not think RN-C was looking for a medication order. The DON stated R9 was having paranoid behavior about people going into her room. The DON stated the paranoid behaviors would be documented in the nurses notes.

The behaviors being monitored by the nursing assistants (NA) on the December 2014, and January 2015 behavior forms were:
-attempts to exit secured doors
-wandering
-verbal agitation/abuse

On 1/22/15, at 9:27 a.m. RN-B stated R9 would come out of her room and stated people were stealing all of her stuff. RN-B stated R9 was not able to state what people were stealing. RN-B stated she would hide her wet clothes in the closet and in the drawers. RN-B stated R9 would also hide hangers in the drawer so no one would take them. RN-B stated R9 had stated to her, see they had taken all of this, referring to the top dresser drawer. RN-B then found out from the staff that all the pull ups were gone from the top drawer so more were added.

At 11:55 a.m. the DON stated she was unable to find a policy related to antipsychotic medications. The DON provided a behavior monitoring policy which read, "target behaviors documented every shift." The DON stated they had not determined the "target behavior" for the use of the Seroquel

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F 329	Continued From page 6	F 329		

yet, and she wanted to talk with RN-B to determine how they should word it. The DON verified the Seroquel was not on the care plan or the target behavior.

At 1:00 p.m. NA-E stated she gave R9 a bath every Tuesday. NA-E stated the night staff was doing R9's bath in the early morning when she would get up at 6:00 a.m. NA-E stated R9 would be crabby for the rest of the day. NA-E stated R9 does not like to change her clothing. NA-E stated she now gives R9 her bath after breakfast and it goes well. NA-E stated she would tell R9 she would wash her clothes and get them back to her and she accepted that. NA-E stated she had not heard R9 being paranoid of different things. NA-E stated R9 does think that people are taking her things.

At 1:13 p.m. the consulting pharmacist (CP) stated a diagnosis of psychosis would be a valid diagnosis to warrant the use of the Seroquel. The CP stated R9 had only been on the Seroquel for a week prior to her review. The CP stated she would also want to know what the behavior R9 exhibited that would constitute paranoid behavior.

At 6:00 p.m. R9's family member (FM)-A was interviewed via phone. FM-A stated R9 had said the phrase "I will kill myself" if she got mad. FM-A stated R9 would be upset if staff came into her room at all. She did not like people in her room as she thought people were stealing. FM-A stated when they saw the physician on 11/5/14, he could see R9 getting more and more agitated, and she was huffing and puffing. FM-A stated the physician did not want to order a medication, he wanted the staff to observe R9 more and see if

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F 329	Continued From page 7 was a necessity. FM-A stated R9 would seem irritated and negative when she came to visit and then she would try and change the topic. FM-A stated, "I would have thought they would have tried the Xanax first." FM-A stated R9 had never been on a medication for paranoia. FM-A stated R9 had been a private person who does not want to share things with family members. On 1/23/15, at 8:54 a.m. the DON stated during the day R9 was suspicious about other residents. The administrator stated at that time that the intent was not to get R9 on an antipsychotic medication. The DON stated they could not start the Seroquel until they received prior authorization, therefore, the Seroquel was not started until 12/18/14. The Behavior Monitoring policy reviewed 3/97, read problem behaviors were also documented in the resident's Plan of Care. This information was updated with any change in the behavior, staff's approach, resident's ability to be redirected and the addition of a psychotropic medication. Identify individual resident "target" behaviors. Add behavior concerns, goals, and interventions to the individual resident care plan.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for	F 356		3/10/15

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F 356	Continued From page 8 resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the nurse posting was accurate regarding the number of nursing staff and actual hours worked per shift for 3 out of 3 days reviewed. This had the potential to affect all 21 residents who resided in the facility as well as any visitors. Findings include: During the initial tour on 1/21/15, at 1:45 p.m. the Riverview Care Center Nursing Staff Directly Responsible for Resident Care posting was	F 356	-Nurse staffing hours form has been reviewed and updated with compliant posting information. Survey results and plans for improvement were discussed at 2/3/15 staff meeting. -Nurse staffing hours are posted in the common area of nursing home and are accessible to residents and visitors. Current policy has been revised and will be updated to include the specific hours worked by nursing staff including CNA, TMA, LPN, and RN start and stop times. Ongoing communications pertaining to the	

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F 356	Continued From page 9 observed located on a clipboard in a clear plastic holder attached to the wall in the main common area across from the nursing station. The posting was dated 1/21/15, and included a census of 21 and displayed the following information for the day shift (6:00 a.m. - 2:30 p.m.): · One registered nurse (RN) with a total of 8 actual hours worked · Zero licensed practical nurses (LPN) · Three nursing assistants (NA) with a total of 24 actual hours worked The nurse staff posting form indicated the following three work shifts: · Day shift - 6:00 a.m. - 2:30 p.m. · Evening shift - 2:00 p.m. - 10:30 p.m. · Night shift-10:00 p.m. - 6:30 a.m. On 1/22/15, at 8:33 a.m. RN-B stated the RNs were scheduled both 12 hour and 8 hour shifts. RN-B confirmed the 12 hour shifts were scheduled from 6 a.m. until 6:30 p.m. or 6:00 p.m. until 6:30 a.m. On 1/23/15, at 8:17 a.m. the facility's nurse staff postings from 1/20/15 - 1/22/15, were reviewed with the director of nursing (DON) and she confirmed: · The 1/20/15, nurse staff posting was inaccurate as it did not include RN-B in the RN numbers and hours worked. In addition, the posting had not accurately reflected start and stop times of the two RNs (RN-C, RN-D) who worked 12 hour shifts. · The 1/21/15, nurse staff posting was inaccurate as it did not include RN-B in the RN numbers and hours worked. In addition, the posting had not accurately reflected the start and stop times of the two RNs (DON, RN-C) who	F 356	plan of corrections will occur at monthly staff meetings. -Daily staffing sheets are given to DON daily for review and filed according to current regulations. Random audits will be completed by the Director of Nursing weekly for 4 weeks of consecutive compliance then decreased to monthly for 6 months of consecutive compliance. Audit findings will be discussed at IDT meetings as well as quarterly quality improvment meetings.	

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F 356	Continued From page 10 worked 12 hour shifts. · The 1/22/15, nurse staff posting was inaccurate as it did not include the DON's hours worked; the start and stop times of RN-B and licensed practical nurse (LPN)-B, who worked 12 hour shifts; LPN-A's three hour shift (5:00 p.m.-8:00 p.m.); and NA-A's shift from 10:00 a.m. - 2:30 p.m. The Posting Direct Care Daily Staffing Numbers policy dated 7/2013, indicated the facility would post daily staffing information which included the total number and actual hours worked for all licensed and unlicensed nursing staff directly responsible for resident care per shift.	F 356		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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.

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K 000	Continued From page 1 Minnesota State Fire Code (2007 edition) that alarm at the nurse's station and on the corridor side of the rooms. The building has an automatic sprinkler system installed in accordance with NFPA 13 Standard for Installation of Automatic Sprinkler Systems (1999 edition). The facility has a capacity of 24 beds and had a census of 22 at the time of the survey. The facility was surveyed as one building. The 1974 portion of the building is not currently being used for healthcare. The requirement at 42 CFR, Subpart 483.70(a) is MET as evidenced by:	K 000		

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 only a suggestion 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	01/23/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On January 21, 22, & 23, 2015, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature." Make a copy of	2 000	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.	

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2 000	Continued From page 1 these orders for your records and return the original to the address below: Minnesota Department of Health 705 Fifth Street NW, Suite A, Bemidji, MN 56601-2933 c/o Lyla Burkman, Unit Supervisor	2 000	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 which 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.	
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct	2 302		4/10/15

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2 302	Continued From page 2 care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Alzheimer's training for 2 of 4 nursing assistants (NA-A, NA-B) and for 1 of 1 registered nurse (RN-A) who provided direct care services. In addition, the facility failed to provide consumers with written information regarding the Alzheimer's training program. This had the potential to affect all 21 residents and their families who resided in the facility. Findings include: NA-A was hired on 7/7/14, and the employee record lacked evidence of having received the required Alzheimer's training.	2 302	-Staff identified in statement of deficiencies have been educated on importance of completing dementia orientation and passing of test within two weeks of education. A notice to consumers regarding details of our traning program will be posted on facility website pending authorization of marketing department. -Personnel files of all staff will be reviewed and staff without documentation of dementia orientation in personel file will be given two weeks to complete and pass dementia orientation test. New staff must complete departmental dementia orientation with a deadline of two weeks given to complete and pass test.	

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2 302	Continued From page 3 NA-B was hired on 12/1/14, and the employee record lacked evidence of having received the required Alzheimer's training. RN-A was hired on 12/15/14, and the employee record lacked evidence of having received the required Alzheimer's training. On 1/22/15, at 1:20 p.m. the director of nursing (DON) confirmed NA-A, NA-B and RN-A had not completed their Alzheimer's training yet and they should have. On 1/23/15, at 8:49 a.m. the administrator confirmed they currently had not provided information to their consumers regarding the details of their Alzheimer's training program, who the facility had trained, how often their staff was trained and the basic information which they covered. No policy related to Alzheimer's training was provided. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) could develop and implement policies and procedures related to the required Alzheimer's training program requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days	2 302	-Yearly hand in hand training will be required for all current and future staff. Mulitiple sessions will be offered for each module of the training. Staff will be required to complete this training as part of their yearly inservice requirements. Staff were educated on our plan to provide ongoing dementia training at the 2/3/15 staff meeting. -Audits for dementia training compliance will be completed by Director 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.	
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision	2 570		4/10/15

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2 570	Continued From page 4 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan for 1 of 3 residents (R9) to include the use of an antipsychotic medication (Seroquel). Findings include: R9's physician's order dated 12/1/14, read Seroquel 25 milligrams (mg) at bedtime for psychosis/paranoia. R9's care plan reviewed 11/20/14, addressed the use of an antianxiety medication. However, the Seroquel was not addressed on the care plan or any behavioral symptoms related to the use of the Seroquel. On 1/22/15, at 11:55 a.m. the director of nursing (DON) stated they had not determined the "target behavior" for the use of the Seroquel yet, and she wanted to talk with registered nurse (RN)-B to determine how they should word it. The DON	2 570	-For the resident in question, the care plan was revised on 1/27/15 to include the administration of Seroquel. Care plan was updated for monitoring of interventions as well on 1/27/15. -All care plans are reviewed quarterly and re-written annually. Care plans are also updated on an ongoing basis as changes arise with their needs and care levels. After any new psychotropic medication is started, the charge nurse will update the care plan and implement clinical monitoring. All residents receiving a psychotropic medication will have a plan of care in place that addresses this area. Care plans are updated with interventions that are individualized for that resident. -Follow-up of any new psychotropic medication will be checked by DON, RCC, or MDS Coordinator the following business day to ensure care plans are updated correctly. Policy and procedures related Behavior monitoring have been	

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2 570	Continued From page 5 verified the Seroquel was not on the care plan or the target behavior. The DON stated the care plans were updated quarterly and stated they try to update more often if able. The Behavior Monitoring policy reviewed 3/97, read problem behaviors were also documented in the resident's Plan of Care. This information was updated with any change in the behavior, staff's approach, resident's ability to be redirected and the addition of a psychotropic medication. Identify individual resident "target" behaviors. Add behavior concerns, goals, and interventions to the individual resident care plan. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) could develop and implement policies and procedures related to care plan revisions. The DON could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days	2 570	reviewed and new policy related to maintaining care plan compliance will be implemented.Improvements to current policy on behavior monitoring will be adressed at staff meeting. -Care plans for residents receiving psychotropic medication will be audited by the Director 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.	
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of	21426		3/2/15

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21426	Continued From page 6 Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 6 employees (NA-C, NA-D) received a two-step tuberculin skin test (TST) prior to resident contact. This had the potential to affect all 21 residents who resided in the facility. Findings include: NA-C's hire date was 11/3/14. NA-C's mantoux (TST) administration form indicated NA-C received step one of the TST on 10/23/14. This test was read on 10/26/14, with a negative result. The facility lacked documentation that NA-C's second step of the TST had been completed. NA-D's hire date was 6/2/2014. NA-D's TST administration form indicated NA-D received step one of the TST on 5/21/14. This test was read on 5/23/14, with a negative result. The facility lacked documentation that NA-D's second step of the TST had been completed. On 1/22/15, at 11:57 a.m. the administrator stated when NA-D was hired she had worked	21426	-All employee personnel files were audited on 1/22/15 for TB testing compliance. Staff without sufficient TB testing documentation must complete a blood draw TB test before returning to work. -Current staff working in our facility are compliant with TB testing requirements per personnel file audit. -Policy updates have been made on organizational TB testing. New employees will no longer be doing a 2 step Mantoux skin test upon hire, they will be doing a one time blood test. This will be required before the employee can attend New Employee Orientation. If employees are hired with prior mantoux testing documented, we will work with them on a case by case basis in accordance with MDH guidelines. -Audit of TB testing documentation for new Care Center employees will be done	

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21426	Continued From page 7 somewhere else. The administrator confirmed according to facility policy NA-D should have provided the facility with documentation that she had received a negative resulting TST within the last year. The administrator verified NA-D is currently working at the facility and that she had not provided the facility with this documentation, nor had she completed the second step of the TST. On 1/22/15, at 12:17 p.m. the administrator confirmed NA-C currently worked at the facility and that she had not received the second step of the TST as directed by facility policy. On 1/22/15, at 1:36 p.m. the infection preventionist (IP) stated the facility recognized that they had not been able to consistently achieve getting the TST completed on their new employees. The IP confirmed NA-C and NA-D should have had their second steps of the TST completed within the one to three weeks following the reading of their first step. On 1/22/15, the human resource generalist confirmed NA-C and NA-D did not have their two-step TST completed. The Employee Health Tuberculosis Program policy dated 1/2011, indicated all healthcare workers at the facility were to have a two-step TST completed. If the initial test was positive, the second test should have been administered one to three weeks later. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures related to the required tuberculosis TST process . The quality assessment and assurance committee could perform random audits to ensure compliance.	21426	before completion of New Employee Orientation dates. Audits will occur for 6 months of consecutive compliance then decreased to yearly by Director of Nursing and reported at quarterly quality improvement meetings.	

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21426	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty (21) days	21426		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R9) had adequate indications warranting the use of an anti-psychotic (Seroquel) medication.	21535	-The resident involved in this situation had care plan reviewed by staff and care plan was updated to include target behaviors and appropriate interventions on 1/27/15. -Target behaviors are identified upon	4/10/15

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21535	Continued From page 9 Findings include: R9'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. 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 1/23/15, at 8:35 a.m. R9 was ambulating in the hallway with her walker. R9 was conversational with the surveyor. 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). 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. 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 and wanted to know if she was safe. Stated, "I don't like it, "If I am not safe I will just kill myself." This	21535	admission and revised quarterly and PRN 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 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 include valid indications of use for all psychotropic medications. In addition, care plans will indicate non-pharmacological interventions to try prior to medication intervention. 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 interventions to provide residents with least restrictive environment possible. - Policy has been reviewed and will be updated to reflect these changes and nursing staff will be re-educated on identifying appropriate indications for use for all behavioral modification interventions. Audits will be completed by Director 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.	

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21535	Continued From page 10	21535		

is a new statement for the resident. Please advise, Thank You."

On 12/1/14, the primary physician ordered Seroquel 25 mg at bedtime for paranoid behaviors. However, an assessment of the resident's condition to determine if behavioral symptoms could be modified with non-pharmacological interventions versus implementing the use of an antipsychotic medication was lacking.

According to the medication administration records (MAR) dated November 2014, through January 2015, R9 did not receive any Xanax PRN during the months of November or January. R9 received 1 PRN dose of Xanax on 12/22/14, due to increased crying and irritation, with the results being "helped."

The care plan reviewed 11/20/14, addressed the use of an antianxiety medication. However, the Seroquel was not addressed on the care plan or any behavioral symptoms related to the use of the Seroquel.

The physician's progress note dated 12/17/14, indicated R9 was recently admitted about a month ago. After a few days of being admitted R9 started having a lot of behavioral issues. R9 was not behaving appropriately and was having paranoia and agitation and was a little difficult to manage for the staff.

On 1/22/15, at 8:54 a.m. the director of nursing (DON) stated RN-C had faxed the physician on 11/29/14, as a FYI (for information only) just to inform the physician. The DON stated she did not think RN-C was looking for a medication order. The DON stated R9 was having paranoid

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	01/23/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 11 behavior about people going into her room. The DON stated the paranoid behaviors would be documented in the nurses notes. The behaviors being monitored by the nursing assistants (NA) on the December 2014, and January 2015 behavior forms were: -attempts to exit secured doors -wandering -verbal agitation/abuse On 1/22/15, at 9:27 a.m. RN-B stated R9 would come out of her room and stated people were stealing all of her stuff. RN-B stated R9 was not able to state what people were stealing. RN-B stated she would hide her wet clothes in the closet and in the drawers. RN-B stated R9 would also hide hangers in the drawer so no one would take them. RN-B stated R9 had stated to her, see they had taken all of this, referring to the top dresser drawer. RN-B then found out from the staff that all the pull ups were gone from the top drawer so more were added. At 11:55 a.m. the DON stated she was unable to find a policy related to antipsychotic medications. The DON provided a behavior monitoring policy which read, "target behaviors documented every shift." The DON stated they had not determined the "target behavior" for the use of the Seroquel yet, and she wanted to talk with RN-B to determine how they should word it. The DON verified the Seroquel was not on the care plan or the target behavior. At 1:00 p.m. NA-E stated she gave R9 a bath every Tuesday. NA-E stated the night staff was doing R9's bath in the early morning when she would get up at 6:00 a.m. NA-E stated R9 would be crabby for the rest of the day. NA-E stated R9	21535		

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21535	Continued From page 12	21535		

does not like to change her clothing. NA-E stated she now gives R9 her bath after breakfast and it goes well. NA-E stated she would tell R9 she would wash her clothes and get them back to her and she accepted that. NA-E stated she had not heard R9 being paranoid of different things. NA-E stated R9 does think that people are taking her things.

At 1:13 p.m. the consulting pharmacist (CP) stated a diagnosis of psychosis would be a valid diagnosis to warrant the use of the Seroquel. The CP stated R9 had only been on the Seroquel for a week prior to her review. The CP stated she would also want to know what the behavior R9 exhibited that would constitute paranoid behavior.

At 6:00 p.m. R9's family member (FM)-A was interviewed via phone. FM-A stated R9 had said the phrase "I will kill myself" if she got mad. FM-A stated R9 would be upset if staff came into her room at all. She did not like people in her room as she thought people were stealing. FM-A stated when they saw the physician on 11/5/14, he could see R9 getting more and more agitated, and she was huffing and puffing. FM-A stated the physician did not want to order a medication, he wanted the staff to observe R9 more and see if was a necessity. FM-A stated R9 would seem irritated and negative when she came to visit and then she would try and change the topic. FM-A stated, "I would have thought they would have tried the Xanax first." FM-A stated R9 had never been on a medication for paranoia. FM-A stated R9 had been a private person who does not want to share things with family members.

On 1/23/15, at 8:54 a.m. the DON stated during the day R9 was suspicious about other residents.

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21535	Continued From page 13 The administrator stated at that time that the intent was not to get R9 on an antipsychotic medication. The DON stated they could not start the Seroquel until they received prior authorization, therefore, the Seroquel was not started until 12/18/14. The Behavior Monitoring policy reviewed 3/97, read problem behaviors were also documented in the resident's Plan of Care. This information was updated with any change in the behavior, staff's approach, resident's ability to be redirected and the addition of a psychotropic medication. Identify individual resident "target" behaviors. Add behavior concerns, goals, and interventions to the individual resident care plan. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) along with the pharmacist could provide training for all nursing staff related to antipsychotic medications. In addition, the DON along with the pharmacist could develop and implement policies and procedures related to the use of antipsychotic medications. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days	21535		