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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OY4E

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 **01/04/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
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 02/24/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 02/24/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/07/2016
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245251

February 24, 2016

Mr. Paul Gaebe - Interim, Administrator
Riverview Hospital & Nursing Home
323 South Minnesota
Crookston, Minnesota 56716

Dear Mr. Gaebe :

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

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

Effective December 12, 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
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 10, 2016

Mr. Paul Gaebe - Interim, Administrator
Riverview Hospital & Nursing Home
323 South Minnesota
Crookston, Minnesota 56716

RE: Project Number S5251037

Dear Mr. Gaebe - Interim:

On December 4, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 19, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On January 4, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 23, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 19, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 12, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 19, 2015, effective December 12, 2015 and therefore remedies outlined in our letter to you dated December 4, 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
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245251	A. Building B. Wing	1/4/2016

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 **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **12/02/2015**	ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **12/12/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/08/2015**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **12/08/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **12/12/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **12/02/2015**
ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **11/30/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **12/08/2015**	ID Prefix **F0366** Reg. # **483.35(d)(4)** LSC	Correction Completed **12/09/2015**
ID Prefix **F0412** Reg. # **483.55(b)** LSC	Correction Completed **12/08/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **12/09/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	01/10/2016	28035	01/04/2016
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/19/2015			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245251	01 - NURSING HOME 01	12/23/2015

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0043	12/10/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By TL/mm	Date: 01/10/2016	Signature of Surveyor: 36536	Date: 12/23/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 11/24/2015		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: OY4E

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

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

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

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

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/19/2015** (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 :
Jana Bromshenshenkel, HFE NEII 12/14/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/07/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

Electronically delivered
December 4, 2015

Mr. Paul Gaebe - Interim Administrato
Riverview Hospital & Nursing Home
323 South Minnesota
Crookston, MN 56716

RE: Project Number S5251037

Dear Mr. Paul Gaebe:

On November 19, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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 December 29, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 29, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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.

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 February 19, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the

Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 19, 2016 (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 electronic 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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

Mark Meath

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	11/19/2015

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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164		12/2/15

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

Electronically Signed | 12/13/2015

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.

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	245251	A. BUILDING _____ B. WING _____	11/19/2015

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 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide privacy during a procedure for 1 of 1 resident (R3) observed to receive a glucometer check in a public area. Findings include: R3's annual Minimum Data Set (MDS) dated 10/18/15, indicated R3 had diagnoses that included dementia and diabetes. The MDS also indicated R3 had severe cognitive impairment. R3's Current Orders included an order dated 9/28/2010, for Accucheck (a glucometer for testing blood sugar) one time per week, twice a day on Tuesday. On 11/17/2015, at 4:55 p.m. registered nurse (RN)-D was observed to gather supplies, wash her hands and prepare the glucometer for testing. RN-D approached R3 who was seated in the open area in the center of the unit and brought him to the front of the nurses station within the same central common area. RN-D donned gloves and proceeded to perform R3's blood glucose check. During this time, five other residents were seated in the common area with full view of the observation.	F 164	Facility timely submits this response and plan of correction pursuant to federal and state law requirements. This response and plan of correction are not admissions, or an agreement, that a deficiency exists or that the statement of a deficiency was correctly cited or factually based and it is not to be construed as an admission against the interest of the facility, the administrator, or any employees, agents, or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same. -11/19/15 Director of Nursing (DON) was notified of occurrence of improper privacy practices for R3. Education was provided immediately on 11/19/15 to all staff working on maintaining privacy for all residents when preforming glucometer checks. Written education was provided in communication book for all staff to review. -Residents having potential for being affected would be identified based on having physician orders for glucometer checks. Care plans will also be updated per policy to include proper privacy	

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F 164	Continued From page 2 On 11/19/2015, at 8:11 a.m. the director of nursing (DON) stated she would expect privacy would be offered to residents prior to any procedure. The DON stated blood glucose checks should not be conducted in a public area. The DON stated the facility did not have a specific privacy policy, however, each resident was provided a booklet regarding residents' rights that addressed privacy. The "Your Rights" booklet dated July 2007, indicated residents had the right to private medical and personal care (including case discussion, consultation, examination, treatment, and activities of personal hygiene like toileting and bathing) except as needed for resident safety and assistance.	F 164	practices to ensure residents rights are maintained. -Education provided at staff meeting on 12/1/15 regarding maintaining privacy in accordance with resident rights and per care plan. -Random audits will be performed by DON or designee to assure proper privacy practices are being followed. Audits will be completed 14 times in first 30 days. Additional audits will be performed as deemed necessary by IDT. Audit finding will be discussed at weekly Interdisciplinary team (IDT) meetings as well as quarterly Quality Assurance (QA) meetings.	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure comprehensive activity assessments had been completed and an ongoing activity program was provided for 3 of 3 residents (R1, R13, R20) reviewed for activities. Findings include: R1 was not comprehensively assessed for	F 248	-Care Plans were reviewed by Activity director (AD) on 11/23/15 for R1, R13, and R20. Care plans were then updated to include specific care areas to address residents individualized activity needs. Activity calendar was updated to reflect staffing levels needed to plan and conduct activities. Written education was provided in communication book on 12/11/15 for all	12/12/15

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F 248	Continued From page 3 activities of interest and provided an ongoing activity program. R1's Diagnosis Report dated 9/1/15, through 9/30/15, identified R1's diagnoses as dementia, macular degeneration (poor vision), obesity and depression. R1's annual Minimum Data Set (MDS) dated 10/11/15, indicated R1 had severe cognitive impairment and was totally dependent on staff for transferring and mobility on and off the unit. R1's annual Activity Care Area Assessment (CAA) dated 10/11/15, indicated due to R1's severely impaired vision, R1 was often limited to activities that were less dependent on visual acuity. In addition, R1 was limited to time out of bed due to risk for skin breakdown. R1's care plan dated 10/22/15, directed staff to offer tactile, olfactory and auditory experiential opportunities within the group programs to promote participation despite R1's visual impairments. The goal was for staff to offer weekly 1:1 visits by talking to resident, reading aloud and reminiscing. On 11/17/15, the facility activity calendar had scheduled recreational/mind games at 4:00 p.m. At this time, R1 was observed in her room, laying in bed. At 7:00 p.m. the activity calendar had scheduled "Wind Down Time." At 7:10 p.m. R1 was observed seated in her wheelchair in the living room area by the aviary. On 11/17/15, between 4:00 p.m. and 7:00 p.m. no structured activity, including what had been identified on the activity calendar was observed to take place.	F 248	staff to review. This included information on importance of activities for social interaction and sensory stimulation. Also the expectation that all staff play an active role in both encouraging residents to participate, and assisting with activities. -11/24/15-11/25/15 all care plans reviewed and updated as needed to assure individualized activity programs are in place. - As of 12/12/15 all residents will have an activity assessment completed upon admission, annually and with any significant change in status. Evening activity aid was onboarded 11/21/15 to provide additional activities for residents. Resident activity participation is monitored daily using activity log, which is then reviewed by AD. Residents activity care area will be reviewed at least quarterly and updated as needed. Charting/Activity Plan of Care policy has been reviewed and updated to reflect these changes. -Random audits will be performed by AD or designee to ensure proper compliance of activity program. Audits will be completed 14 times in first 30 days. Additional audits will be performed AS deemed necessary by IDT. Audit finding will be discussed at weekly IDT meetings as well as quarterly QA meetings.	

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F 248	Continued From page 4 On 11/18/15, at 9:30 a.m. R1 was observed in her room, lying in bed. The room was quiet with no music on. On 11/18/15, at 10:34 a.m. R1 was observed seated in her wheelchair in the common area by the aviary while a dice game activity went on in the activity room. R1 had not been encouraged or offered to attend this activity. On 11/18/15, at 1:30 p.m. the activity calendar had scheduled "Arts And Crafts" however, this activity was observed to not occur. On 11/18/15, at 2:51 p.m. R1 was observed in her room, lying in bed. At this time, bingo was being played in the dining room area. R1 had not been encouraged or offered to attend this activity. On 11/18/15, at 3:25 p.m. the activity director (AD) confirmed even though the activity calendar had activities scheduled for 11/17/15, due to staffing, no activities had been offered on this day. In fact, because the activity aide (AA) had been on vacation, even though the activity calendar had at least four activities scheduled daily for 11/13, 11/14, 11/15, 11/16, and 11/17, no structured activities had been offered or available to any of the residents for these days. The AD stated when AA was on vacation she tried to fill in, however her schedule often had not allowed this to happen. The AD confirmed for October and November: · the scheduled 7:00 p.m. "wind down time" activity on the calendar had not been offered · the scheduled four activities for all Fridays had not been offered	F 248		

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F 248	Continued From page 5 · the activities scheduled for every other Sunday had not been offered · no activities had been offered on Saturdays past 1:30 p.m. On 11/19/15, at 7:40 a.m. AA confirmed when she was not working, the activities sometimes had not been done. AA stated R1 was scheduled for 1:1 weekly visits. On 11/19/15, at 8:20 a.m. registered nurse (RN)-C stated R1 enjoyed music and church activities. RN-C confirmed the facility's individual resident preferences assessment for activities was to be completed upon admission then annually. On 11/19/15, at 8:46 a.m. AA verified "Arts And Crafts" had not been offered to the residents as indicated on the activity calendar for 11/18/15, at 1:30 p.m. AA stated usually if R1 had participated in activities it were the activities scheduled for later on in the day. On 11/19/15, at 11:04 a.m. the director of nursing (DON) stated activities had been an issue since she had started in March 2015. R1's Daily Activity Log for October 2015, indicated: · 1:1 visits had occurred four times (10/1, 10/4, 10/10,10/13) · no 1:1 visits had occurred beyond 10/13/15 · R1 had participated in recreational games four times (10/5, 10/12, 10/13)	F 248		

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F 248	Continued From page 6 R1's Daily Activity Log for November 2015, indicated: · 1:1 visits had occurred twice (11/3, 11/5) · R1 had participated in recreational games four times (11/2, 11/4, 11/10, 11/11) · R1 had attended church service twice (11/5, 11/12) · R1 had attended trivia once (11/10) · R1 had attended a movie once (11/5) R1's activity preference and interest assessment was not provided and could not be located within R1's medical record. R1's medical record lacked documentation regarding R1's engagement and participation in the activity program. On 11/19/15, at 8:50 a.m. the AD provided the facility activity calendars for October 2015, and November 2015, and the following was revealed: · For November (11/1/15 -11/18/15) the facility had scheduled 74 activity opportunities and 31 activities had been actually offered · For October 2015 the facility had scheduled 128 activity opportunities and 72 activities had been offered R13 was not comprehensively assessed for activities of interest and provided an ongoing activity program. R13's Face Sheet dated 11/19/15, indicated R13 was admitted to the facility in June of 2015, with diagnoses that included, but were not limited to Alzheimer's dementia.	F 248		

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F 248	Continued From page 7 R13's admission MDS dated 6/29/15, identified R13's lifetime occupation/vocation was affiliated with the catholic church, R13 had severe cognitive impairment, had mood symptoms that included feeling down or depressed and felt bad about herself. The MDS indicated R13 had no inappropriate behavior symptoms, and had the following activities of interest: reading books and newspapers, listening to music, keeping up with the news, doing group activities, participating in favorite activities and participation in religious activities. The MDS also indicated R13 could make herself understood, and had the ability to clearly understand others, had no signs and symptoms of delirium, had no inappropriate behavior symptoms and could ambulate independently. R13's comprehensive activity assessment completed at the time of or after R13's admission to the facility was not found in R13's medical record. A preadmission activity assessment was found in the record which was completed prior to R13's admission. The assessment identified R13 spent an average of 1/3-2/3 of her day engaged in activities prior to admission and activities of interest included cards and other games, exercise/sports, spiritual /religious activities, walking outdoors, watching television, gardening, helping others, conversing, music, pet visits, outdoor games and wood working. The assessment had not identified specific activities of interest of which R13 actually participated. R13's activity's care plan dated 9/23/15, had one entry dated 9/23/15, which indicated R13 liked to watch baseball. There was no further information related to activities identified. No other care plans related to activities for R13 had been developed.	F 248		

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F 248	Continued From page 8 R13 was observed on all days of the survey 11/17/15, from 2:30-7:00 p.m.; 11/18/15, from 9:30 a.m. to 4:00 p.m.; and 11/19/15, from 7:00 a.m. to 12:30 p.m. and at no time did R13 participate in an activity. Review of the activity calendar for 11/17/15, revealed the following activity's and times: -10:00 a.m. Baking -1:30 p.m. Facts on Danny Devito -4:00 p.m. Recreational games and mind games -7:00 p.m. Wind down time. On 11/19/15, at 9:26 a.m. the AD verified none of the above activities were offered to R13 or any other resident on the special care unit because there was not enough activity staff to provide the activities. Review of the activity calendar for 11/18/15, the following was to be offered: -10:00 a.m. Dice games -catholic communion (no time specified) -1:30 arts and crafts -4:00 p.m. Recreational and Mind games -7:00 p.m. Wind down Time. Of the activities listed, R13 was offered and refused to participate in dice games (this was not an activity of interest). Catholic communion was not offered to R13 or any of the residents. The 1:30 p.m. arts and crafts was not offered for any of the residents including R13. R13 did not participate in Mind Games at 4:00 p.m. and 7:00 p.m. Wind down time was not offered.	F 248		

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F 248	Continued From page 9 The activity calendar for 11/19/15, identified 10:00 a.m. Church service, R13 did not attend the church service. R13's activity participation log from 9/1/15-11/18/15, were reviewed and the following was indicated: -Catholic communion or mass was not been offered to R13 at all. - In September 2015, R13 watched television on two occasions, participated in trivia on three occasions, listened to live music on one occasion, attended one party, went to one church service & one devotion, one baking class, one pet therapy session, one bingo game and one recreational game a total of 20 activities in 31 days, and there were 20 days R13 had not participated in any activities. -From September 22 through October 14, 2015, (23) days there were no activities documented at all for R13. -From 10/14/15, -10/31/15, R13 participated in trivia on one occasion, attended two parties, participated in three recreational games, had 2 1:1 visits, and attended bingo on three occasions for a total of 11 activities in 31 days. - In November 2015, R13 participated in one live music session, one party, 1:1 visit and two sessions of bingo for a total of six activities in 18 days. There were no activity progress notes documented in R13's record that identified if R13 liked any of the activities she attended, if R13 had any type of inappropriate behavior during activities or actively participated in the activities she had attended.	F 248		

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F 248	Continued From page 10 On 11/18/15, at 10:02 a.m. nursing assistant (NA)-A stated R13 rarely ever attended activities. On 11/18/15, at 10:11 a.m. RN-B stated since admission to the facility, R13 had become increasingly isolated to her bedroom and the only activity she knew R13 really enjoyed was watching baseball. RN-B stated R13 rarely ever participated in structured activities. On 11/18/15, at 2:51 p.m. AA stated R13 most often refused group activities and confirmed 1:1 activities had not been offered to R13. On 11/19/15, at 9:26 a.m. the activity director (AD) confirmed R13 was not comprehensively assessed for activity interests and an activity care plan for R13's activity interests had not been developed. The AD stated although activity staff had identified R13 had refused most all activities, a 1:1 visit schedule had not been developed so R13 could better participate in meaningful activities. The AD also stated she was not aware activity progress notes needed to be completed in order to identify how each resident was participating in activities of interest and if the residents care plan was meeting the residents individual activity needs. R20 was not comprehensively assessed for activities of interest and provided an ongoing activity program. R20's significant change MDS dated 9/6/15 indicated R20 had moderate cognitive impairment, had minimal depression and felt down, depressed or hopeless. The MDS also indicated R20 was diagnosed with dementia, anxiety disorder and cancer, required staff	F 248		

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oversight for transfers and mobility and activity preferences included enjoyed keeping up with the news, participating in favorite activities and religious events and doing things with groups of people.

R20's care plan dated 9/25/15, lacked reference to any activities, goals and approaches.

A progress note dated September 2015, indicated R20 liked bingo, talking with others, did not like being in her room all the time, liked to throw the ball back and forth with the other residents' and she mostly liked going outside. The note also indicate R20 stated she would live outside if she could because she loved the fresh air. The note further indicated R20 really liked 1:1 visits and as of lately had coming out of her room to attend activities but didn't always participate but liked to watch too.

A progress note dated Oct. 2015, indicated R20 loved to keep herself busy and especially liked going outside and playing with big ball. The note also indicated R20 had not let her hearing loss keep her from attending activities.

R20's medical record lacked any type of comprehensive activity assessment.

R20's Daily Activity Log for October 2015, indicated the following:
-R20 participated in recreational games five times (10/5, 10/12, 10/19, 10/29)
-R20 attended social times with staff/peers twice (10/6, 10/27)
-R20 attended arts and crafts once (11/28)
-R20- no 1:1 visits provided

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R20's Daily Activity Log for November 2015, indicated the following:
-R20 attended Bingo four times (11/3, 11/7, 11/11, 11/18)
-R20 participated in recreational games 4 times (11/2, 11/3, 11/4, 11/11)

On 11/17/15, from 3:15 p.m. R20 was continuously observed until 7:45 p.m. At 3:15 p.m. R20 was observed in her room seated in the wheelchair. The TV was on but R20 was not facing it. During this observation time, R20 was not observed to participate in activities nor were activities offered to any of the residents.

On 11/18/15, at 3:09 p.m. NA-E stated R20 really liked activities and would attend any she could.

On 11/19/15, at 8:03 a.m. R20 stated the residents' did not do activities "very often" and there was no activities offered on the weekends. R20 stated yesterday they played two games of bingo which she really liked, but did not get to play it very often. R20 also stated sometimes the residents' played with a ball, but that was not very often either. R20 stated the residents' could do more things but no one talks about doing activities so there was not much to do. R20 added, she really liked sewing or stitching and would like to try to do that.

On 11/19/15, at 10:36 a.m. NA-B stated R20 was confused at times but was very cognitively aware of her surroundings. NA-B stated there had not been very many activities offered. Some movies on the TV, but there just had not been any activity staff here to provide the activities. NA-B stated she knew R20 really liked activities and staff tried to do things with her, but it was hard to do

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F 248	Continued From page 13 activities and also get their work done. No policy related to the completion of activity assessments nor activity program was provided.	F 248		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to apply foam pressure relieving boots as directed by the care plan in order to minimize the development of pressure ulcers for 1 of 3 residents (R1) observed who was at risk for pressure ulcer development. Findings include: R1's Diagnosis Report dated 9/1/15, through 9/30/15, identified R1's diagnoses as dementia, cellulitis (skin infection), chronic kidney disease and obesity. R1's care plan dated 3/22/15, directed staff to apply foam boots to R1's feet when in bed to relieve pressure on her heels. R1's care sheet (undated) directed the nursing assistants (NA) to apply foam boots to R1's feet when in bed. On 11/18/15, at 10:16 a.m. NA-D was observed to enter R1's room and change R1's incontinent brief. During the brief change, R1 was observed	F 282	-11/18/15 DON was notified of occurrence of improper use of pressure relieving boots for R3. Resident heals were assessed by DON on 11/18/15 and found to have no evidence of pressure areas as skin was pink and blanchable. Heel boots immediately put on R3 per care plan. Education was provided on 11/18/15 to all staff working and written education was provided in communication book for all staff to review. -All residents are assessed on admission, quarterly, and as needed per Braden skin assessment for need of pressure relieving booties. Residents□ use of pressure relieving devices is updated on care plan to reflect their individual needs. -Education provided at staff meeting on 12/1/15 regarding Proper use of Pressure relieving devices and importance of care plan compliance. -Random audits will be performed by DON or designee to assure proper use of	12/8/15

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F 282	Continued From page 14 to not have the bilateral foam boots (heel protectors) on her feet. After incontinent cares were completed, NA-D exited the room without applying R1's foam boots as directed by the care plan. On 11/18/15, at 1:09 p.m. R1 was observed seated in her wheelchair in the common area. NA-C wheeled R1 to her room and NA-C and NA-A proceeded to transfer R1 from her wheelchair into bed using a mechanical lift. NA-C and NA-A changed R1's incontinent brief and positioned her in bed. However, NA-C or NA-A had not applied the foam boots on R1's feet. On 11/18/15, at 2:54 p.m. registered nurse (RN)-B confirmed R1 should have heel boots on when R1 was in bed. On 11/18/15, at 3:11 p.m. the director of nursing (DON) verified R1's care plan directed staff to place foam boots on R1's feet when she was in bed and confirmed it was her expectation staff followed R1's care plan regarding pressure ulcer prevention interventions. On 11/18/15, at 3:18 p.m. the DON entered R1's room and confirmed the foam boots were not currently on R1's feet. The DON opened R1's closet door, obtained the foam boots and placed them on R1's feet. The DON verified the foam boots should have been on R1 when R1 was in bed. Care Plan, Comprehensive, Interim, Short Term dated 3/12, indicated each resident would have a comprehensive care plan developed which included interventions/approaches to help the resident meet the identified focused goals. In	F 282	pressure relieving devices. Audits will be completed 14 times in first 30 days. Additional audits will be performed as deemed necessary by IDT. Audit finding will be discussed at weekly IDT meetings as well as quarterly QA meetings.	

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F 282	Continued From page 15 addition, the identified interventions/approaches would be implemented.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure interventions for pressure ulcer prevention had been implemented according to the resident's assessed needs for 1 of 3 residents (R1) observed for pressure ulcer prevention. Findings include: R1's Diagnosis Report dated 9/1/15, through 9/30/15, identified R1's diagnoses as dementia, cellulitis (skin infection), chronic kidney disease and obesity. R1's annual Minimum Data Set (MDS) dated 10/11/15, indicated R1 had severe cognitive impairment and required extensive assist with bed mobility, toileting, personal hygiene, was totally dependent on staff for transferring and was identified at risk for pressure ulcer development.	F 314	-11/18/15 DON was notified of occurrence of improper use of pressure relieving boots for R3. Resident heals were assessed by DON on 11/18/15 and found to have no evidence of pressure sores as skin was pink and blanchable. Heel boots immediately put on R3. Education was provided on 11/18/15 to all staff working and written education was provided in communication book for all staff to review. -All residents are assessed on admission, quarterly, and as needed per Braden skin assessment for need of pressure relieving booties. Residents□ use of pressure relieving devices is updated on care plan to reflect their individual needs. -Education provided at staff meeting on 12/1/15, regarding Proper use of Pressure relieving devices and importance of care	12/8/15

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F 314	Continued From page 16 Pressure ulcer treatment interventions included pressure relieving devices in chair and bed and a turning and repositioning program. R1's annual Care Area Assessment (CAA) dated 10/11/15, indicated R1 was high risk for pressure ulcer development related to R1's need for extensive to total assist with all activities of daily living. R1's care plan dated 3/22/15, directed staff to apply foam boots to R1's feet when in bed to relieve pressure on her heels. R1's care sheet (undated) directed the nursing assistants (NA) to apply foam boots to R1's feet when in bed. R1's Braden Scale (assessment tool utilized for predicting pressure ulcer risk) dated 10/9/15, indicated R1 was at high risk for the development of a pressure ulcer. On 11/18/15, at 10:16 a.m. NA-D was observed to enter R1's room and change R1's incontinent brief. During the brief change, R1 was observed to not have the bilateral foam boots (heel protectors) on her feet. After incontinent cares were completed, NA-D exited the room without applying R1's foam boots as directed by the care plan. On 11/18/15, at 1:09 p.m. R1 was observed seated in her wheelchair in the common area. NA-C wheeled R1 to her room and NA-C and NA-A proceeded to transfer R1 from her wheelchair into bed using a mechanical lift. NA-C and NA-A changed R1's incontinent brief and positioned her in bed. However, NA-C or NA-A had not applied the foam boots on R1's feet.	F 314	plan compliance. -Random audits will be performed by DON or designee to assure proper use of pressure relieving devices. Audits will be completed 14 times in first 30 days. Additional audits will be performed as deemed necessary by IDT. Audit finding will be discussed at weekly IDT meetings as well as quarterly QA meetings.	

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F 314	Continued From page 17 On 11/18/15, at 1:15 p.m. NA-C stated to prevent skin breakdown for R1 the staff were to reposition her and check and change R1's brief every two hours. NA-C lacked acknowledging the need for R1 to have foam boots on when she was in bed. On 11/18/15, at 2:54 p.m. registered nurse (RN)-B confirmed R1 should have heel boots on when R1 was in bed. On 11/18/15, at 3:11 p.m. the director nursing (DON) confirmed it was her expectation that staff followed R1's care plan regarding pressure ulcer prevention interventions. DON verified R1's care plan directed staff to place foam boots on R1's feet when she was in bed. On 11/18/15, at 3:18 p.m. the DON entered R1's room and confirmed the foam boots were not currently on R1's feet. The DON opened R1's closet door, obtained the foam boots and placed them on R1's feet. At this time, the DON confirmed R1's heels were reddened, however blanchable. The DON verified the foam boots should have been on R1 when R1 was in bed. Prevention of Pressure Ulcers policy dated 12/09, directed staff to utilize devices to relieve pressure on heels.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 315		12/12/15

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F 315	Continued From page 18 catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident who had a change in bladder function was comprehensively assessed for 1 of 3 residents (R13) in the facility who were reviewed for urinary incontinence. Findings include: R13's Face Sheet dated 11/19/15, indicated R13 was diagnosed with Alzheimer's dementia. R13's admission Minimum Data Set (MDS) dated 6/29/15, indicated R13 was occasionally incontinent of urine (less than 7 episodes of incontinence a week), required limited assistance of one person with toilet use, was not on a toilet training program, had severe cognitive impairment and could ambulate independently. R13's quarterly Minimum Data Set (MDS) dated 9/20/15, indicated R13 was always incontinent of of urine (no episode's of continence a week), required supervision assistance of one person with toilet use, was not on a toilet training program, had severe cognitive impairment and could ambulate independently. R13's care plan dated 7/1/15, indicated R13 experienced urinary incontinence due to	F 315	-Bladder assessment was completed on R13 and care plan was updated on 12/12/15. -It is the policy of RiverView Care Center that residents bladder status be assessed on admission, yearly and as needed per RAI guidelines. Residents bladder status is also monitored quarterly by Charge RN. If residents level of incontinence changes a full bladder assessment will be completed as stated per policy. -Staff meeting held on 12/1/15. Education was given to licensed staff regarding importance of incontinence awareness. Also discussed the need for accurate assessments and evaluation of the resident current level of functioning. Policy was provided to staff and reviewed at that time to assure understanding of bladder assessment protocols within facility. -MDS variance reports will be discussed weekly at IDT meetings to assure correct procedures are followed. This will also allow better visualization of all residents current level of functioning and any changes that may have occurred in their level of functioning.	

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F 315	Continued From page 19	F 315		

diagnosis of constipation. The care plan also indicated R13 had stress, urge and functional bladder incontinence and directed staff to administer medications as ordered by the physician, encourage fluids, provide limited assistance for toileting and to provide incontinence care after each incontinent episode.

An undated bladder assessment was found in R13's medical record, however it lacked a history of R13's bladder incontinence, assessment of post void residuals,medications that could affect continence (R13 was taking the diuretic Lasix 20 mg every other day), identification of the type of bladder incontinence, or the determination of R13's need for a bladder retraining or restorative plan. The assessment was not comprehensive.

R13's Urinary Incontinence Care Area Assessment (CAA) dated 6/29/15, had not identified all of the diseases and conditions that affected R13's continence, medications that affected R13's continence, modifiable factors contributing to R13's incontinence, and the analysis of the CAA had not identified R13's pattern of incontinence from a voiding diary to determine an appropriate toileting plan.

On 11/18/15, at 10:02 a.m. nursing assistant (NA)-A stated R13 was very modest and most often refused to allow NA-A into the bathroom with her while toileting. NA-A stated R13 often wore pull up style incontinent products and managed independently.

On 11/18/15, at 11:58 a.m. NA-A was observed assisting R13 to ambulate into the dining room for the noon meal. NA-A asked R13 if she needed to use the bathroom prior to the meal. R13 stated

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F 315	Continued From page 20 yes, entered the bathroom independently, closed the door and stated to NA-A, "now don't peek in on me." On 11/19/15, at 8:37 a.m. the director of nursing confirmed R13 had not been comprehensively assessed for urinary incontinence at the time of admission or when R13's continence had declined as identified by the quarterly MDS dated 9/20/15. The DON confirmed R13 did not have a bladder retraining program developed after admission or after the quarterly MDS had identified a decline in R13's continence on 9/20/15. No policy related to the completion of a bladder assessment was provided.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure fall interventions had been developed and implemented following each fall for 1 of 3 residents (R3) in the facility reviewed for accident hazards.	F 323	-R3 care plan was reviewed by DON and updated 12/2/15 to include individualized fall interventions to aid in prevention of future falls. -All residents are evaluated on admission for potential fall risk by charge RN. In accordance with RAI guidelines and	12/2/15

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F 323	Continued From page 21 Findings include: R3's clinical diagnoses report dated 9/30/15, identified R3 had diagnoses that included dementia, major depressive disorder and unspecified psychosis. R3's annual Minimum Data Set (MDS) dated 10/18/15, indicated R3 had 3 fall incidents since the last quarterly MDS assessment dated 7/26/15, R3 had severe cognitive impairment, long and short-term memory impairment, required extensive assistance of two persons for bed mobility, was totally dependent on two or more staff for transfers, was unable to ambulate and required the use of a wheelchair for mobility. R3's care plan for falls with a problem start date of 3/31/10, identified R3 was at risk for falls related to having bad knee's and antidepressant use. The fall interventions included the following: Give verbal reminders regarding the need for help. On 10/15/15, a hoyer was implemented for transfers. R3 used a large/wide bed in the low position to the floor. A silent alarm was implemented to alert staff if R3 attempted to independently get out of bed. R3 had anti-roll back brakes on the wheelchair. R3's environment was to remain clutter free, and the call light was to be in reach at all times. On 11/18/15, at 9:42 a.m. R3 was observed in a wide bed which was low to the floor and the call light was within reach. R3's room was free of obstacles and clutter, the floor was carpeted so there wasn't an issue with a slippery surface, however an alarm device was not observed. -At 9:45 a.m. nursing assistant (NA)-G explained there was an alarm device on the bed which	F 323	facility policy, they are also evaluated quarterly and with any significant changes. -Education was provided at staff meeting on 12/1/15 on the facility's current fall policy. Staff discussed the significance of the post fall huddle and the importance of including all of the staff that are present at time of the fall. The post fall huddle is when staff will discuss why a fall occurred and what can be done to prevent it from happening again. These interventions are then documented in the post fall observation and submitted to the DON. Effective 12/1/15 proper fall interventions will be implemented after every fall to prevent the recurrence of falls. Ongoing fall prevention training will be given to include the importance of being proactive in preventing falls vs being reactive after a fall occurs. Resident falls and interventions will be reviewed at weekly IDT meetings. Falls are then closed by DON, with the recommendations given by the IDT as well, in order to assure proper fall interventions are in place. -Effective 12/1/15 all falls reports will be reviewed by DON to assure they are being completed properly and necessary information is included. Falls are also tracked and reported upon at quarterly QA meetings.	

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F 323	Continued From page 22	F 323		

turned the call light on if R3 attempted to exit the bed and this was called a silent alarm because R3 would not hear an alarm sound.
-At 11:00 a.m. R3 was observed seated in his wheelchair which had anti-roll back brakes applied.

R3's fall incident's were reviewed from 4/23/15-10/30/15, and it was noted that R3 had 10 falls during that period of time. R3 had not suffered a major injury with any of the 10 falls. Following each fall, R3 was not consistently assessed and an investigation for causal factors was not consistently completed. Additionally, specific interventions to minimize further fall incidents were not consistently developed or implemented.

The fall incidents that occurred on 4/30/15, 5/23/15, 6/6/15, and 8/3/15, lacked assessment of causal factors contributing to R3's fall incidents and specific interventions had not been developed to minimize further fall incidents.

The fall incidents that occurred on 9/17/15, 9/18/15, 9/23/15, and 10/30/15, had adequate assessment of causal factors that contributed to R3's falls, but lacked development of appropriate fall intervention's based on the causal factors. The fall incident report described the intervention developed following each of these falls were "staff monitoring," and the incident report had not identified what staff monitoring meant or included.

The director of nursing (DON) was interviewed on 11/19/2015, at 10:33 a.m. and confirmed R3's fall incidents had not been comprehensively assessed, causal factors contributing to R3's fall incidents had not been consistently identified and

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F 323	Continued From page 23 specific interventions had not been developed following each fall incident. The DON confirmed staff monitoring was not a specific fall intervention for R3 because it did not identify how to better care for R3 to minimize ongoing falls. A policy related to fall assessment / interventions was not provided.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nutritional interventions had been consistently implemented for 1 of 1 resident (R13) in the sample who was under ideal body weight. Findings include: R13's Face Sheet dated 11/19/15, indicated R13 was diagnosed with Alzheimer's dementia. R13's admission Minimum Data Set (MDS) dated	F 325	-11/18/15 DON was notified of R13 not receiving breakfast, and lack of 2nd alternative meal being offered. DON spoke directly with care staff on 11/18/15 regarding the facility procedure for providing residents with nutritionally equivalent substitutes. Written education was provided by Dietician as well, and placed in communication book on 11/19/15 for all staff to review. -Dietician reviewed all weights for facility on 11/23/15. IDT met on 11/24/15 and	11/30/15

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F 325	Continued From page 24 6/29/15, indicated R13 weighed 130 pounds, required supervision and set up assistance with eating and had no deficits with chewing or swallowing. R13's quarterly Minimum Data Set (MDS) dated 9/20/15, indicated R13 weighed 125 pounds, required supervision and set up assistance with eating and had no deficits with chewing or swallowing. Review of R13's weight record indicated a weight of 114 on 11/5/15, (a weight loss of 16 pounds since admission), and R13's weight was 111.6 at the lowest weight recorded on 11/3/15. Review of the comprehensive nutrition assessment completed by the registered dietician dated 9/21/15, identified R13 had a significant change in nutritional status, R13 had an ideal weight change of 124-128 pounds and R13's goal body weight was 125-135 pounds. Review of the registered dietician (RD) progress notes from 7/2/15-11/10/15, identified the RD had assessed R13's nutritional status at least monthly. -The progress note dated 9/21/15, identified R13 had inappropriate behavior related to oral intake which included spitting food out and stating she could not swallow. The RD progress note identified R13's swallowing ability had been assessed by a speech language pathologist and it was determined R13 didn't have any physical deficits related to swallowing, but it was thought that R13's complaints regarding the inability to swallow were related to R13's advancing dementia. -The RD progress note dated 10/26/15, identified	F 325	discussed findings. No other resident concerns were identified. -As of 11/19/15 the facility menu is posted in dining room in order to be readily available to all staff and residents. New employee orientation list was also updated on 11/30/15 to include knowledge of alternative meal choices. -Random audits will be performed by Social Service Designee to assure proper knowledge of menu choices. Audits will be completed 14 times in first 30 days. Additional audits will be performed as deemed necessary by IDT. Audit finding will be discussed at weekly IDT meetings as well as quarterly QA meetings.	

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R13 had a significant weight loss since admission and R13 had inappropriate eating behaviors that included spitting out food and refusing to eat food. The RD implemented interventions which included offering R13 Boost Plus and Breeze nutritional supplements with meals and between meals.

R13's care plan dated 7/1/15, identified the following problem: Potential for alteration in nutrition
secondary to diagnoses of advanced Alzheimer's, Dementia... agitation with constant wandering, significant wt loss (11/15), behaviors of spitting out food, refusing to go to the DR for meals, throws food from room trays in garbage / hall, refusing supplements, snacks and favorite foods. The plan directed staff to provide Boost Plus and Breeze nutritional supplements 240 ml three times a day with meals and in between meals as per nursing discretion and to encourage food, snacks, supplements, beverages during waking periods and provide verbal encouragement to eat/drink. The care plan also indicated R13 ate meals in the dinning room, was provided with verbal cues as to meal times, location of dinning room and if R13 refused to go to the dinning room for meals a room tray was provided, R13 was independent with eating following some assist with meal setup (i.e.: opening cartons, cutting foods, pouring liquids, applying condiments) and R13's guardian requested a clothing protector be worn at all meals.

On 11/18/15, at 10:25 a.m. R13 was observed to come out of her bedroom accompanied by nursing assistant (NA)-A. R13 asked NA-A twice if it was time for breakfast and if she could have breakfast. NA-A stated to R13 that she had slept

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through breakfast and the next meal was lunch which would be served in about an hour. NA-A asked R13 if she wanted a drink and R13 stated yes, she would like a coca cola. NA-A informed R13 there was no coca cola and offered R13 three types of juice. R13 agreed to having a glass of grape juice in which NA-A provided and R13 drank the whole glass while seated in the dinning room. R13 was not offered or provided any breakfast on 11/18/15.

On 11/18/15, at 12:07 p.m. R13 was observed during the noon meal. R13 was served a pulled pork barbeque sandwich on a bun, coleslaw, green beans, chocolate milk and peach cobbler. R13 took the pulled pork sandwich and threw it in the trash can that was positioned under the table. R13 then scraped all of the other items served to her into the garbage can. R13 took two bites of peach cobbler and put the rest of the meal into the garbage can. R13 stated she did not like any of the items served and attempted to leave the dinning room. R13 also refused to drink the chocolate nutritional supplement offered during the meal. NA-E asked R13 if there was anything else she would like and R13 stated no and left the dinning room. NA- A, NA-E, and NA-F were interviewed at this time and were asked if there was an alternative meal option that R13 could have been served and all of them stated they were not aware of any alternative meal options available from the dietary department. At 12:28 p.m. NA-F was observed to offer R13 cheerios but R13 refused to eat anything.

On 11/18/15, at 11:22 p.m. The director of nursing (DON) confirmed R13 was below ideal body weight and stated R13 should have been provided breakfast after waking up and stated the

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F 325	Continued From page 27 facility always had cereal, toast and many other breakfast items always available for residents to eat if they slept through breakfast. The DON stated in the past two weeks she had educated all of the staff on opportunity's to increase R13's oral intake including offering substitute food items when items were refused and providing R13 food that could be easily consumed while walking such as sandwich's and cookies. No policy related to the provision of nutritional supplements / intake was provided.	F 325		
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		12/8/15

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F 329	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a gradual dose reduction of antipsychotic medication and tapering of antianxiety medication was attempted for 1 of 5 residents (R6) reviewed for unnecessary medications. Findings include: R6's ICD-10 Diagnosis Report dated 11/19/15, indicated R6 had diagnoses that included psychosis, dementia without behavioral disturbance, anxiety disorder and Alzheimer's disease. R6's annual Minimum Data Set (MDS) dated 10/4/15, indicated R6 had severe cognitive impairment and was independent for bed mobility, transfer and ambulation. The MDS indicated R6 expressed little interest in doing things and feeling down, depressed or hopeless 2-6 days during the assessment period. The MDS also identified the following behavioral symptoms during the assessment period: -other behavioral symptoms not directed toward others on 1-3 days, -wandering behaviors that significantly intruded on the privacy of others on 4-6 days The MDS further indicated R6 did not exhibit hallucinations or delusions, physical or verbal behavior directed at self/others or rejection of	F 329	-R6 Primary physician was contacted on 11/26/15 with orders to see mental health provider for use of psychotropic medications. Appointment was set up for first possible opening (1/4/16). -Chart review was completed by Pharmacist on 11/30/15 and Recommendations given to nursing team. No gradual dose reductions were missed for any other residents. -Pharmacy access to Electronic medical record was adjusted to allow for a more thorough review of medical charts. Resident medication reductions will be monitored by DON for proper compliance with current psychotropic medication policy. If recommendations are not addressed by provider fax will be sent requesting documentation as pharmacy recommendations state. -Random audits will be performed by DON or designee to assure proper compliance with gradual dose reductions. Audits will be completed 14 times in first 30 days. Additional audits will be performed if deemed necessary by IDT. Audit finding will be discussed at weekly IDT meetings as well as quarterly QA meetings.	

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F 329	Continued From page 29 care and she received antipsychotic and antianxiety medication daily. R6's Mood State Care Area Assessment (CAA) dated 10/8/15, indicated R6 was on Xanax (an antianxiety medication), Seroquel (an antipsychotic medication) and Aricept (a medication that treats symptoms of Alzheimer's disease such as confusion or dementia) for mood/behavior. The CAA indicated R6 liked to keep busy doing things, always joined in activities, was usually pleasant, but if she didn't get "her way" or if things weren't done the way she felt they should be done, she got angry. R6's Behavioral Symptoms CAA dated 10/8/15, indicated R6 liked to walk around with walker for exercise and was known to close the door to other residents' rooms if she saw them open. The CAA indicated it was not always possible to determine if R6 was wandering or if she had a goal in mind. On 11/18/2015, at 9:54 a.m. R6 was observed playing a dice game in activity area with other residents. R6 was pleasant and smiling and participated in the activity. No negative behaviors or anger at others exhibited. On 11/18/2015, at 11:57 a.m. R6 was observed seated at a chair in the dining room, cursing after being served her meal. Nursing assistant (NA)-D enquired as to what was wrong. R6 did not answer but muttered under her breath. R6 continued to eat her meal independently without further incident.	F 329		

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On 11/18/2015, at 12:20 p.m. R6 ambulated independently from the dining room with walker. Social service designee and R6 reminisced about a past barn dance R6 smiled and laughed.

R6's Physician Order Report dated 10/19/2015, - 11/19/2015, indicated R6 had medication orders that included alprazolam (an antianxiety medication) 0.25 milligrams (mg) 1 tab at bedtime and 1 tab three times a day as needed (PRN) started on 11/6/14, and quetiapine (an antipsychotic medication) 25 mg 1 tab at bedtime started on 12/1/14.

R6's undated Care Plan identified a problem of Mood/Behavior with a goal of: moods and behaviors would be managed with therapeutic approaches and the lowest effective dose of psychotropic medication. The Care Plan directed staff to administer Seroquel (quetiapine) and alprazolam as ordered.

Review of R6's Medication Administration History (MAR) from 9/1/15, to 11/18/15, indicated R6 received alprazolam 0.25 mg 1 tab at bedtime and quetiapine 25 mg 1 tab at bedtime daily. The MAR indicated R6 did not receive any PRN doses of alprazolam during this time period.

Review of Pharmacist's Problem List form identified a pharmacist reviewed R6's medication regimen on the following dates: 12/25/14, 1/6/20, 1/28/15, 2/28/15, 3/30/15, 4/30/15, 5/29/15, 6/27/15, 7/27/15, 8/31/15, 9/29/15 and 10/24/15.

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F 329	Continued From page 31 On 4/30/15, the pharmacist recommended R6's behaviors being treated with Seroquel and Xanax be listed. On 9/29/15, the pharmacist recommended the effectiveness of Seroquel and Xanax for the control of R6's anxiety and psychosis be mentioned in the next physician note. No recommendations regarding dose reduction of Seroquel (quetiapine) or tapering of Xanax (alprazolam) were made. Review of R6's physician notes from 11/5/14, to present, revealed the following: --12/17/15: behaving not appropriately and having paranoia and agitation and a little difficult to manage for staff. Seroquel 25 mg at night time started. --1/13/15: apparently doing okay and easily redirectible by staff and she follows commands. Continue current medications --4/20/15: continues to have some behavior issues though it seems to not be very frequent. Continue medications as prescribed for now. --7/9/15: behavior issues from time to time mostly controlled with current medications. Continue with current medications. --8/28/15: continue all medications as prescribed. Attempted dose reduction of Seroquel (quetiapine), tapering of Xanax (alprazolam) or documentation regarding contraindication of dose reduction/tapering were lacking. On 11/19/2015, at 8:59 a.m. registered nurse (RN)-C confirmed there had been no gradual dose reduction of Seroquel or tapering of Xanax attempted. The director of nursing (DON) verified the last dose of PRN Xanax was given 4/27/15.	F 329		

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F 329	Continued From page 32 On 11/19/2015, at 10:00 a.m. the consultant pharmacist (CP) confirmed there had been no attempt for dose reduction of Seroquel or tapering of Xanax dose for R6. The CP verified a pharmacy recommendation for dose reduction of Seroquel and tapering of Xanax or documentation of contraindication was lacking and should have been identified. On 11/19/2015, at 10:26 a.m. the DON stated she would have expected a dose reduction/tapering be attempted or contraindication be documented, as required. The Psychotropic Medication policy dated 3/10/15, indicated psychotropic medications included: antianxiety/hypnotic, antipsychotic and antidepressant classes of drugs. The policy also indicated a gradual dose reduction (GDR) would be done at least every 6 months for those residents receiving psychotropic medication. If GDR was contraindicated for resident, physician was to document the clinical reasoning in progress notes every 6 months.	F 329		
F 366 SS=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 366	-11/18/15 DON was notified of R13 not	11/30/15

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F 366	Continued From page 33 review, the facility failed to ensure substitute food choices of similar nutritive value to the meal served was offered to 1 of 1 resident (R13) observed to refuse the meal served and was not offered an alternative food choice. This practice had the potential to affect all 22 residents residing in the facility who had received meals in the facility. Findings include: R13's Face Sheet dated 11/19/15, indicated R13 was diagnosed with Alzheimer's dementia. R13's quarterly Minimum Data Set (MDS) dated 9/20/15, indicated R13 weighed 125 pounds, required supervision and set up assistance with eating and had no deficits with chewing or swallowing. R13's care plan dated 7/1/15, identified the following problem: Potential for alteration in nutrition secondary to diagnoses of advanced Alzheimer's, Dementia... agitation with constant wandering, significant wt loss (11/15), behaviors of spitting out food, refusing to go to the dining room for meals, throws food from room trays in garbage / hall, refusing supplements, snacks and favorite foods. The plan directed staff to provide Boost Plus and Breeze nutritional supplements 240 milliliters (ml) three times a day with meals and in between meals as per nursing discretion and to encourage food, snacks, supplements, beverages during waking periods and provide verbal encouragement to eat/drink. The care plan also indicated R13 ate meals in the dinning room, was provided with verbal cues as to meal times, location of dinning room and if R13 refused to go	F 366	receiving breakfast, and lack of 2nd alternative meal being offered. DON spoke directly with care staff on 11/18/15 regarding the facility procedure for providing residents with nutritionally equivalent substitutes. Written education was provided by Dietician as well, and placed in communication book on 11/19/15 for all staff to review. -Dietician reviewed all weights for facility on 11/23/15. IDT met on 11/24/15 and discussed findings. No other resident concerns were identified. -As of 11/18/15 the facility menu is posted in dining room in order to be readily available to all staff and residents. New employee orientation list was also updated on 11/30/15 to include knowledge of alternative meal choices. -Random audits will be performed by Social Service Designee to assure proper knowledge of menu choices. Audits will be completed twice a week for 4 weeks of consecutive compliance then decreased to weekly for one month of consecutive compliance. Audit finding will be discussed at weekly IDT meetings as well as quarterly QA meetings.	

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to the dinning room for meals a room tray was provided, R13 was independent with eating following some assist with meal setup (i.e. opening cartons, cutting foods, pouring liquids, applying condiments) and R13's guardian requested a clothing protector be worn at all meals.

On 11/17/15, at 6:32 p.m. registered nurse (RN)-D indicated resident meals were sent to the unit from the kitchen and the nurse on duty for the shift was responsible for serving the meal and she had served the meal on this date. RN-D stated pancakes, sausage and strawberries were served and no alternatives to this meal were sent from the kitchen. When asked what she would do if a resident did not like that choice or refused their meal, RN-D indicated they could make soup or toast.

On 11/18/15, at 10:25 a.m. R13 was observed to come out of her bedroom accompanied by nursing assistant (NA)-A. R13 asked NA-A twice if it was time for breakfast and if she could have breakfast. NA-A stated to R13 that she had slept through breakfast and the next meal was lunch which would be served in about an hour. NA-A asked R13 if she wanted a drink and R13 stated yes, she would like a Coca Cola. NA-A informed R13 there was no Coca Cola and offered R13 three types of juice. R13 agreed to having a glass of grape juice in which NA-A provided and R13 drank the whole glass while seated in the dinning room. R13 was not offered or provided any food items / breakfast on 11/18/15.

On 11/18/15, at 12:07 p.m. R13 was observed during the noon meal. R13 was served a pulled pork barbeque sandwich on a bun, coleslaw,

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green beans, chocolate milk and peach cobbler. R13 took the pulled pork sandwich and threw it in the trash can that was positioned under the table. R13 then scraped all of the other items served to her into the garbage can. R13 took two bites of peach cobbler and put the rest of the meal into the garbage can. R13 stated she did not like any of the items served and attempted to leave the dinning room. R13 also refused to drink the chocolate nutritional supplement offered during the meal. NA-E asked R13 if there was anything else she would like and R13 stated no and left the dinning room. NA- A, NA-E, and NA-F were interviewed at this time and were asked if there was an alternative meal option that R13 could have been served and all of them stated they were not aware of any alternative meal options available from the dietary department. At 12:28 p.m. NA-F was observed to offer R13 cheerios but R13 refused to eat anything.

On 11/18/15, at 11:22 p.m. The director of nursing (DON) confirmed R13 was below ideal body weight and stated R13 should have been provided breakfast after waking up and stated the facility always had cereal, toast and many other breakfast items always available for residents to eat if they slept through breakfast. The DON stated in the past two weeks she had educated all of the staff on opportunities to increase R13's oral intake including offering substitute food items when items were refused and providing R13 food that could be easily consumed while walking such as sandwiches and cookies.

On 11/18/15, at 12:56 p.m. NA-A was observed helping with the lunch meal. When asked, what the alternative foods were for lunch today, NA-A stated, I don't know what the alternative is, if they

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F 366	Continued From page 36	F 366		

don't like what they are served, we can usually heat up some soup." NA-A stated, "I don't know about the same nutritive value, you would have to ask the nurse."

On 11/19/2015, at 11:55:04 a.m., the dietary manager (DM) stated her expectation was for nursing home staff to call the kitchen for alternative food items when a resident does not want what was served. The alternative food items offered should be of the same nutritive value to foods being served. We have a computer program that identifies the individual residents likes and dislikes and it also provides an alternative equivalent to what the foods being served are. The DM further stated, it was on the weekly menu **if an alternative is needed please call 9442**. With the computer program a quick substitute can be provided. The DM stated if the resident declined an equivalent nutritive food item, then we would offer the soup or a sandwich. The DM stated staff training had been completed and nursing home staff should have been oriented to the food items and how to make substitutions if a resident does not like a food item.

On 11/19/2015, at 11:37 a.m. the clinical dietitian (CD) stated the facility had a very thorough process for assessing resident dietary needs, likes and dislikes. The CD stated the computer system identified alternatives that were resident focused and it would be the expectation staff would call for the alternative, before serving a can of soup.

On 11/19/15, at 11:45 a.m., the DON, confirmed, it was her expectation staff would call the kitchen for a substitute food item of equivalent nutritive

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 366	Continued From page 37 value for residents. The facility policy, Alternative meal selections for the Memory Care Unit dated 11/14 indicated: if a resident dislikes the meal items served nursing home staff would call the kitchen.	F 366		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dental services were provided for an identified dental need for 1 of 3 residents (R7) reviewed for dental services. Findings include: R7's Face Sheet dated 11/19/15, indicated R7 was diagnosed with dysphagia, dementia, schizophrenia and anxiety. R7's quarterly Minimum Data Set's (MDS) dated 7/5/15, and 9/27/15, had not identified R7 had broken or missing teeth.	F 412	-R7 oral status was assessed by DON on 11/19/15 and no visible signs of infection or irritation were observed or felt. When asked if having oral pain R7 responded "No". Also denied any pain with chewing and brushing. R7 guardian was contacted on 11/20/15 and did not wish for R7 to be seen by a dentist at this time. -All residents oral status is assessed by and RN on admission, quarterly, and as needed per RAI guidelines. If resident is noted to be experiencing oral pain, staff will contact dental provider for the earliest possible appointment. -Current Dental Care policy has been	12/8/15

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F 412	Continued From page 38 R7's care plan dated 8/6/12, indicated "Oral/Dental: Dental consult 8/6/12 Son wishes nothing to be done unless problems." On 11/17/15, at 2:50 p.m. R7 was observed to have missing and broken teeth. R7 stated she did not have any trouble chewing foods and did not have oral pain. On 11/18/15, at 12:09 p.m. R7 was observed during the noon meal. R7 was provided a mechanical soft diet and did not have any trouble eating/chewing the meal which included a pulled pork sandwich, coleslaw, baked beans, green beans and peach cobbler. Review of R7's medical record was reviewed and a comprehensive oral assessment was not found. The following progress notes revealed: A progress note dated 5/6/15, indicated R7's mouth was assessed and found to have lower gum swelling, the teeth on R7's left side of the oral cavity were inflamed and the teeth on the right side were broken, pointed and sharp. The progress note indicated an infection was in question and an appointment for a dentist to assess R7 would be made. Further review of the progress notes revealed R7 had not been evaluated by a dentist and there was no documentation as to the reason why R7 had not been evaluated by a dentist. There was no documentation which indicated R7's son was notified of the oral status. A progress note dated 5/16/15, indicated R7's oral cavity had been assessed by a registered nurse and indicated R7 had only four teeth on the bottom, only remnants of teeth on the top and	F 412	reviewed and updated to reflect most recent guidelines set forth by the department of health. Education provided at staff meeting on 12/1/15. Updated dental policy placed in communication book and was reviewed by all staff. -Random audits will be performed by DON or designee to assure proper dental practices are being followed. Audits will be completed 14 times in first 30 days. Additional audits will be performed as deemed necessary by IDT. Audit finding will be discussed at weekly IDT meetings as well as quarterly QA meetings.	

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F 412	Continued From page 39 question if they had been ground down through use. Palpated on each area where teeth remained and where they were mostly gone. R7 denied pain to any area. Gums reddened around each tooth remnant on the top, from chewing. Gums not swollen or infected looking and there was no drainage. R7 was on a mechanical soft with ground meat diet. No further progress notes regarding R7's teeth or oral cavity were found in R7's medical record. The record also lacked indication R7 was provided a dental consult. Additionally, the progress notes had not identified that R7's son had been notified of R7's inflamed teeth identified on 5/6/15. On 11/19/15, at 10:56 a.m. registered nurse (RN-B) confirmed a comprehensive oral assessment had not been completed and R7 had not been provided a dental consult even though the aforementioned progress notes written on 5/6/15, and 5/16/15, identified R7 had broken, missing teeth and inflamed gums. RN-B stated R7's medical record had not indicated why a dentist had not been consulted.	F 412		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		12/9/15

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F 428	Continued From page 40 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the consultant pharmacist identified irregularities related to the lack of a gradual dose reduction (GDR) of antipsychotic medication, tapering of antianxiety medication or contraindication of GDR/tapering documented for 1 of 5 residents (R6) whose medication regimen was reviewed. Findings include: R6's ICD-10 Diagnosis Report dated 11/19/15, indicated R6 had diagnoses that included psychosis, dementia without behavioral disturbance, anxiety disorder, and Alzheimer's disease. R6's annual Minimum Data Set (MDS) dated 10/4/15, indicated R6 had severe cognitive impairment and was independent for bed mobility, transfer and ambulation. The MDS indicated R6 expressed little interest in doing things and feeling down, depressed or hopeless 2-6 days during the assessment period. The MDS also identified the following behavioral symptoms during the assessment period: -other behavioral symptoms not directed toward others on 1-3 days, -wandering behaviors that significantly intruded on the privacy of others on 4-6 days The MDS further indicated R6 did not exhibit hallucinations or delusions, physical or verbal behavior directed at self/others or rejection of care and she received antipsychotic and antianxiety medication daily.	F 428	-R6 Primary physician was contacted on 11/26/15 with orders to see mental health provider for use of psychotropic medications. Appointment was set up for first possible opening (1/4/16). -Chart review was completed by Pharmacist on 11/30/15 and Recommendations given to nursing team. No gradual dose reductions were missed for any other residents. -The consultant pharmacist shall review monthly both the electronic chart and written chart for physician progress notes and MAR changes. If the pharmacist finds that during the first year an anti-psychotic medication is started that two attempts at Gradual Dose Reduction (GDR) have not been done, the pharmacist shall write in the pharmacy tab to the physician that a GDR needs to be attempted or the reason why not must be documented in a physician progress note. If such GDR is not attempted and the physician has not written a response either in the pharmacy tab or physician progress note, then the consultant pharmacist shall notify nursing who must fax to the physician the pharmacist□s request for a GDR. The response, whether facsimile or verbal, shall be further documented in the resident□s chart. For the resident to whom the GDR was not attempted, nursing must contact the physician and inform them of the F428 tag and ask if a GDR should be attempted. Whether yes or no, the	

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F 428	Continued From page 41 R6's Mood State Care Area Assessment (CAA) dated 10/8/15, indicated R6 was on Xanax (an antianxiety medication), Seroquel (an antipsychotic medication) and Aricept (a medication that treats symptoms of Alzheimer's disease such as confusion or dementia) for mood/behavior. The CAA indicated R6 liked to keep busy doing things, always joined in activities, was usually pleasant, but if she didn't get "her way" or if things weren't done the way she felt they should be done, she got angry. R6's Behavioral Symptoms CAA dated 10/8/15, indicated R6 liked to walk around with walker for exercise and was known to close the door to other residents' rooms if she saw them open. The CAA indicated it was not always possible to determine if R6 was wandering or if she had a goal in mind. The Physician Order Report dated 10/19/2015 - 11/19/2015, indicated R6 had medication orders that included alprazolam (an antianxiety medication) 0.25 milligrams (mg) 1 tab at bedtime and 1 tab three times a day as needed (PRN) started on 11/6/14, and quetiapine (an antipsychotic medication) 25 mg 1 tab at bedtime started on 12/1/14. R6's undated Care Plan identified a problem of Mood/Behavior with a goal of: moods and behaviors would be managed with therapeutic approaches and the lowest effective dose of psychotropic medication. The Care Plan directed staff to administer Seroquel (quetiapine) and alprazolam as ordered. Review of R6's Medication Administration History (MAR) from 9/1/15 to 11/18/15, indicated R6	F 428	physician must address this issue in a progress note to be placed in the resident□s chart. -Random audits will be performed by Pharmacy Director to assure proper compliance with gradual dose reductions.	

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F 428	Continued From page 42	F 428		

received alprazolam 0.25 mg 1 tab at bedtime and quetiapine 25 mg 1 tab at bedtime daily. The MAR indicated R6 did not receive any PRN doses of alprazolam during this time period.

Review of Pharmacist's Problem List form identified a pharmacist reviewed R6's medication regimen on the following dates: 12/25/14, 1/6/20, 1/28/15, 2/28/15, 3/30/15, 4/30/15, 5/29/15, 6/27/15, 7/27/15, 8/31/15, 9/29/15 and 10/24/15. On 4/30/15, the pharmacist recommended the behaviors being treated with Seroquel and Xanax be listed. On 9/29/15, the pharmacist recommended the effectiveness of Seroquel and Xanax for the control of R6's anxiety and psychosis be mentioned in the next physician note. No recommendations regarding GDR of Seroquel (quetiapine) or tapering of Xanax (alprazolam) were made nor was the lack of documentation of contraindication of GDR/tapering identified.

Review of the physician notes from 11/5/14 to present, revealed the following:
--12/17/15: behaving not appropriately and having paranoia and agitation and a little difficult to manage for staff. Seroquel 25 mg at night time started.
--1/13/15: apparently doing okay and easily redirectible by staff and she follows commands. Continue current medications
--4/20/15: continues to have some behavior issues though it seems to not be very frequent. Continue medications as prescribed for now.
--7/9/15: behavior issues from time to time mostly controlled with current medications. Continue with current medications.
--8/28/15: continue all medications as prescribed. Attempted GDR of Seroquel (quetiapine),

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F 428	Continued From page 43 tapering of Xanax (alprazolam) or documentation regarding contraindication of GDR/tapering were lacking. On 11/19/2015, at 8:59 a.m. registered nurse (RN)-C confirmed there had been no gradual dose reduction of Seroquel or tapering of Xanax attempted. The director of nursing (DON) verified the last dose of PRN Xanax was given 4/27/15. On 11/19/2015, at 10:00 a.m. consultant pharmacist (CP) confirmed there had been no attempt for dose reduction of Seroquel or tapering of Xanax dose for R6. CP verified a pharmacy recommendation for dose reduction of Seroquel and tapering of Xanax or documentation of contraindication was lacking but should have been identified. On 11/19/2015 10:26:00 AM DON stated she would have expected a dose reduction/tapering be attempted or contraindication be documented as required. The Psychotropic Medication policy dated 3/10/15, indicated pharmcy to review residents' drug regime monthly. The policy also indication gradual dose reduction (GDR) would be done at least every 6 months for those residents receiving psychotropic medication. If GDR was contraindicated for resident, physician to document clinical reasoning in progress notes every 6 months.	F 428		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire marshal Division on November 24, 2015. At the time of this survey RiverView Nursing Home 01 Main Building was not found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

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

Electronically Signed | 12/11/2015

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.

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K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency 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	K 000		

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K 000	Continued From page 2 (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 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 NOT MET as evidenced by:	K 000		
K 043 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Patient room doors are arranged so that the patient can open the door from inside without using a key. (Special door locking arrangements are permitted in mental health facilities.) 19.2.2.2.2 This STANDARD is not met as evidenced by: Based on observation, and staff interview the facility had cross corridor doors and exit doors that did not meet the requirements of NFPA 101 LSC (00) Section 19.2.1 This deficient practice could affect the safety of all residents, staff and visitors, if quick access to an exit was needed.	K 043	Posting of door codes will be placed near the Exit #19 on south side, west side, and cross-corridor doors. Paul Gaebe, Care Center Administrator, will be responsible for making the correction. Monitoring of the correction to	12/10/15

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K 043	Continued From page 3 Findings include: On the facility tour between 09:00 and 12:30 conducted on November 24, 2015, observations revealed that exit number 19 on the south side and one exit on the west side, plus two sets cross corridor doors used key pads to control access. At the time of the inspection there were no postings of the door codes to allow for quick access in case of an emergency. This deficient condition was verified by the Environmental Services Supervisor (JT).	K 043	prevent recurrence of this deficiency shall be accomplished by visual inspection by Paul Gaebe - Care Center Administrator, Caitlin Browning – Director of Nursing, Kalie Crayton – Activities Director /COTA, and the Charge Nurse on duty.	