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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: QX30

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00540N

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245614**

2.STATE VENDOR OR MEDICAID NO.
(L2) **257150000**

3. NAME AND ADDRESS OF FACILITY
(L3) **HILLCREST SENIOR LIVING**
(L4) **311 BROADWAY AVENUE NE**
(L5) **RED LAKE FALLS, MN** (L6) **56750**

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) **04/01/2008**

6. DATE OF SURVEY **03/21/2014** (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 **30** (L18)

13.Total Certified Beds **30** (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
	30			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Lyla Burkman, Unit Supervisor — 03/28/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 05/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/06/2008
(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
03/24/2014
(L33)

DETERMINATION APPROVAL

CCN: 24-5614

On March 21, 2014 and March 25, 2014 a Post Certification Revisit (PCR) was completed by review of the plan of correction to verify correction of deficiencies issued pursuant to the Janauary 23, 2014 standard survey. Based on the plan of correction it was determined the facility has corrected the deficiencies issued pursuant to the January 23, 2014 standard survey, effective March 4, 2014. Refer to the CMS 2567b forms for both health and life safety code for the results of this revisit.

Effective March 4, 2014, the facility is certified for 30 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5614

May 16, 2014

Ms. Nicolai Berg, Administrator
Hillcrest Senior Living
311 Broadway Avenue Northeast
Red Lake Falls, Minnesota 56750

Dear Ms. Berg:

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 March 4, 2014 the above facility is certified for:

30 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 30 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 letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 28, 2014

Ms. Nicolai Berg, Administrator
Hillcrest Senior Living
311 Broadway Avenue Northeast
Red Lake Falls, Minnesota 56750

RE: Project Number S5614008

Dear Ms. Berg:

On February 18, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 23, 2014. 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 March 21, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 25, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 23, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 4, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 23, 2014, effective March 4, 2014 and therefore remedies outlined in our letter to you dated February 18, 2014, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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

Sincerely,

Mark Meath

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

Enclosure

cc: Licensing and Certification File 5614r14.rtf

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
245614	A. Building B. Wing	3/21/2014

Name of Facility	Street Address, City, State, Zip Code
HILLCREST SENIOR LIVING	311 BROADWAY AVENUE NE RED LAKE FALLS, MN 56750

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 **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	Correction Completed **03/04/2014**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **03/04/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **03/04/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/04/2014**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **03/04/2014**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **03/04/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **03/04/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/04/2014**	ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **03/04/2014**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **03/04/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **03/04/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **03/04/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/04/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/LB	03/28/2014	28035	03/21/2014
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
1/23/2014			

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245614	A. Building / B. Wing: 01 - MAIN BLDG	3/25/2014

Name of Facility	Street Address, City, State, Zip Code
HILLCREST SENIOR LIVING	311 BROADWAY AVENUE NE RED LAKE FALLS, MN 56750

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	03/04/2014	ID Prefix Reg. # NFPA 101 LSC K0072	03/04/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By MM/PS	Date: 03/28/2014	Signature of Surveyor: 03006	Date: 03/25/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 1/23/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: QX30

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00540N

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245614**
2.STATE VENDOR OR MEDICAID NO.
(L2) **257150000**

3. NAME AND ADDRESS OF FACILITY
(L3) **HILLCREST SENIOR LIVING**
(L4) **311 BROADWAY AVENUE NE**
(L5) **RED LAKE FALLS, MN** (L6) **56750**

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) **04/01/2008**

6. DATE OF SURVEY **01/23/2014** (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 **30** (L18)

13.Total Certified Beds **30** (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
	30			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Vienne Andresen, HFE NEII 03/14/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 03/19/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/06/2008
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 3/24/2014 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN: 24-5614

At the time of the January 23, 2014 standard survey the facility was not in substantial compliance with Federal participation requirements, that included an investigation of complaint number . 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.

Refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8507

February 18, 2014

Ms. Nicolai Berg, Administrator
Hillcrest Senior Living
311 Broadway Avenue Northeast
Red Lake Falls, Minnesota 56750

RE: Project Number S5614008

Dear Ms. Berg:

On January 23, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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;

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 4, 2014, 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 March 4, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition

of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 23, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human

Services that your provider agreement be terminated by July 23, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

5433s14.rtf

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245614	A. BUILDING _____ B. WING _____ RECEIVED MAR 07 2014	01/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST SENIOR LIVING	311 BROADWAY AVENUE NE RED LAKE FALLS, MN 56750

(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 PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	F 000		03/04/2014 Completion date for all F tags, see attachments - mpm
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those	F 156	See attached plans of correction.	

Approved
3/7/14
c Attachments

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 3/27/14

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

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F 156	Continued From page 1 other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and	F 156		

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F 156	Continued From page 2 advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) or a uniform denial letter upon termination of all Medicare Part A skilled services for 2 of 3 residents (R19 and R1) reviewed for liability notice and beneficiary appeal rights review. Findings include: R19 was discharged from Medicare Part A on 9/13/13, and remained in the facility until he expired on 12/9/13. The facility did not provide	F 156		

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F 156	Continued From page 3 R19 and/or his legal representative with a SNFABN/ Centers for Medicare and Medicaid Services (CMS)-10055 or a uniform denial letter to inform him of potential liability for non-covered services and of his right to appeal the denial to Medicare. R1 was discharged from Medicare Part A on 7/29/13, and remained in the facility until her discharge on 8/31/13. The facility did not provide R1 and/or her legal representative with a SNFABN/ CMS-10055 or a uniform denial letter to inform her of potential liability for non-covered services and of his right to appeal the denial to Medicare. During an interview on 1/23/13, at 2:30 p.m. the Administrator confirmed that he had not provided R19 and R1 the SNFABN or one of the five uniform denial letters. The facility policy/procedures related to SNF DETERMINATION ON CONTINUED STAYwas requested but not provided.	F 156		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by:	F 242	See attached plans of correction	

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F 242	Continued From page 4 Based on interview and document review, the facility failed to accommodate resident choice with regards to the frequency of baths provided, for 2 of 2 residents (R1 and R22) reviewed for choices. Findings include: R1's quarterly Minimum Data Set (MDS) dated 12/25/13, revealed diagnoses including dementia and panic disorder with agoraphobia. The MDS indicated R1 had moderately impaired cognition, required extensive assistance for personal hygiene and physical assistance for bathing. During interview on 1/21/14, at 4:00 p.m. R1 stated she was not able to choose how many times a week she could take a bath or a shower and was currently able to bathe only once per week. During a follow-up interview on 1/22/14, at 11:00 a.m. R1 reiterated she could not bathe as often as she liked. She stated that she preferred to bathe every morning. R1 added, "If I could have a bath or have a shower and stand under that hot shower it would be heaven." R1 stated that she voiced her opinion to several of the nursing assistants (NAs) who had promised to fit her in for an extra bath if there was time. R1 stated that she did not often receive more than one bath per week. NA-A was interviewed on 1/23/14, at 8:34 a.m. and stated that she was aware that R1 had requested an extra bath the week prior, but was not aware if she had received the extra bath. Upon review of the bathing flow sheet, NA-A confirmed that from 12/1/13, through 1/23/14, R1 had received only one bath each week.	F 242		

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F 242	Continued From page 5 Although R1's social history/lifestyle profile dated 6/21/13, instructed to specify her bathing preferences, R1's bathing preferences were not addressed. R1's plan of care (POC) developed 7/6/13, also lacked direction for R1's preferences for bathing frequency. However, review of R1's satisfaction survey dated 7/25/13, identified she preferred a whirlpool bath two times per week. The administrator was interviewed on 1/23/14, at 9:34 a.m. and stated that the facility's social service designee (SSD) did a resident satisfaction survey on a monthly basis and if a resident expressed they wanted an additional bath, then the facility found a way to make it work. R22's quarterly MDS dated 12/5/13, revealed diagnoses including muscle weakness, cerebral vascular accident (stroke), and paraplegia (impairment in motor or sensory function of the lower extremities). The MDS indicated R22 was cognitively intact, required physical assistance for transfers and required set up assistance for bathing. On 1/21/14, at 3:33 p.m. R22 was interviewed regarding bathing preferences. He stated he was not able to choose how many times per week he took a bath or shower and currently only received one bath per week. R22 also indicated that he had spoken with SSD about receiving a bath twice per week, but "so far had not seen this put into place." During a follow-up interview on 1/23/14, at 8:44 a.m. R22 added he had	F 242		

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F 242	Continued From page 6 communicated his desire for an extra bath on his last satisfaction survey. He stated that it had been awhile since that had been done, but estimated it was in 8/13. Review of the Social History/Lifestyle Profile dated 2/12/13, lacked assessment of R22's bathing preferences in the daily routine section as suggested. R22's POC dated 1/5/14, directed staff to provide assistance with a weekly whirlpool bath/shower. The POC did not identify R22's preference for receiving baths twice per week. On 1/23/14, at 8:28 a.m. NA-A stated that to her knowledge, R22 had not asked for additional baths. On 1/23/14, at 8:40 a.m. the administrator stated that SSD would have been working with R22 on his request, and was expected to communicate back to the nursing department in order to accommodate his request. Administrator indicated he expected the request to be accommodated as soon as possible. Review of R22's satisfaction survey dated 7/13, revealed R22 was okay with one whirlpool bath/shower per week. During interview on 1/23/14, at 12:52 p.m. R22 clarified that he had discussed his preference for multiple whirlpools per week with SSD at the time of the satisfaction survey, but decided he was satisfied with one bath per week at the time; however, he added, a follow up conversation took place with SSD in late 8/13, when he indicated he wanted to receive two baths per	F 242		

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F 242	Continued From page 7 week. SSD was not available for interview.	F 242		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to update each resident's plan of care (POC) to include range of motion (ROM) services when recommended by physical therapy (PT), for 1 of 1 resident (R11) reviewed for ROM. Findings include:	F 280	See Attached Plans of Correction.	

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F 280	Continued From page 8 On 10/13, a quarterly Minimum Data Set (MDS) note indicated R11 was unable to ambulate due to weakness related to pneumonia. The note identified R11's normal gait as shuffling, with the ability to ambulate only short distances while receiving extensive assistance from two staff. A therapy evaluation was indicated for strengthening. Review of a PT evaluation dated 12/30/13, directed R11 was to be seen three times weekly for treatment. On 1/8/14, R11 was discontinued from PT services with recommendations which included initiation of an active assist/passive ROM (AA/PROM) program for his upper and lower extremities for ten repetitions, with right heel cord and hamstring stretches. R11's POC dated 1/4/14, indicated he was to receive strengthening exercises with an exercise group, three times weekly. An AA/PROM program was not added to his POC as per the PT recommendation on 1/8/14. During interview on 1/22/14, at 10:30 a.m. nursing assistants (NA)-A and NA-B stated R11 did not ambulate and he was not on their list for receiving ROM services. On 1/23/14, at 10:00 a.m. the director of nursing (DON) verified the PT's recommendations for R11 had not been initiated and R11 was not receiving ROM to all four extremities with right heel cord and hamstring stretches. The facility's Nursing Rehabilitation & Restorative Care Program policy dated 5/03, indicated the function of the rehabilitation program was to	F 280		

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F 280	Continued From page 9 provide restoration, improvement, or maintenance of the resident's optimal level of function. The policy indicated a resident would be placed on a rehabilitation program following an evaluation from the physical therapist.	F 280		
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 interview and document review, the facility failed to provide ambulation services as directed in the plan of care (POC), for 1 or 1 resident (R5) who required assistance with ambulation. Findings include: R5's POC dated 1/19/14, directed staff to walk him to and from meals with a walker and assistance of two, with a gait belt for safety. Review of R5's monthly Rehab Data Flow Sheets revealed the following: -10/13, indicated R5 ambulated three out of 93 opportunities. -11/13, indicated R5 ambulated seven out of 90 opportunities. -12/13, indicated R5 ambulated 16 out of 93 opportunities. -1/14, indicated R5 ambulated 13 out of 68 opportunities.	F 282	See attached plans of correction.	

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F 282	Continued From page 10 On 1/23/14, at 11:07 a.m. nursing assistant (NA) -A stated R5 frequently ambulated with assistance of one and a walker, to and from the bathroom throughout the day and was supposed to ambulate to meals but had not been doing so recently. NA-A confirmed it had been a couple of months since R5 had ambulated to/from meals. On 1/23/14, at 1:40 p.m. director of nursing (DON) confirmed R5 had not received ambulation services as directed by his POC.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation services in order to improve or maintain functional abilities for 1 of 1 resident (R5) who required an ambulation program. Findings include: R5's Care Area Assessment (CAA) dated 8/14/13, revealed he required extensive to total assistance for activities of daily living (ADLs) due to generalized weakness. The CAA indicated R5 was referred to physical therapy (PT) and occupational therapy (OT) for ADL and ambulation ability. R5 was expected to improve performance with therapy and maintenance	F 311	See Attached Plans of Correction	

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F 311	Continued From page 11 program was to be in place when discharged from therapy to maintain ADL and ambulation ability. The Outreach Physical Therapy Inpatient Plan of Treatment dated 8/15/13, included discharge recommendations for a daily ambulation program to and from all meals with a four-wheeled walker. A restorative nursing program of group exercise, three times per week was also recommended to promote and maintain his right-lower extremity strength for functional mobility. Assistance of one staff was recommended for all transfers and ambulation. R5's plan of care (POC) dated 1/19/14, directed staff to walk him to and from meals with a walker and assistance of two, with a gait belt for safety. The Rehab Data Flow Sheet for nursing assistants (NAs) directed R5 was to be ambulated with a walker to breakfast, dinner and supper. The flow sheets revealed the following: -10/13, indicated R5 ambulated three out of 93 opportunities. -11/13, indicated R5 ambulated seven out of 90 opportunities. -12/13, indicated R5 ambulated 16 out of 93 opportunities. -1/14, indicated R5 ambulated 13 out of 68 opportunities. On 1/23/14, at 11:07 a.m. NA-A stated R5 frequently ambulated with assistance of one and a walker, to and from the bathroom throughout the day and was supposed to ambulate to meals but had not been doing so recently. NA-A confirmed it had been a couple of months since	F 311		

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F 311	Continued From page 12 R5 had ambulated to/from meals. During observation on 1/23/14, at 12:46 p.m. R5 wheeled himself back to his room in his wheelchair after dinner. On 1/23/14, at 1:40 p.m. director of nursing (DON) confirmed R5 had not received ambulation services as directed by his POC.	F 311		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion (ROM) serviceas to minimize the risk for functional decline, for 2 of 2 residents (R11 and R20) reviewed for ROM. Findings include: R11 was not provided with a ROM program as per the recommendation of his physical therapist (PT) and was not provided with an exercise group as per his written plan of care. R11's significant change Minimum Data Set (MDS) dated 1/10/14, revealed diagnoses	F 318	See attached plans of correction.	

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F 318	Continued From page 13 including dementia and Parkinson's disease. The MDS indicated R11 had severely impaired cognition and required extensive to total assistance for activities of daily living (ADLs). R11's ADL Care Area Assessment (CAA) dated 1/13/14, indicated R11 was a high fall risk. On 10/13, a quarterly MDS note indicated R11 was unable to ambulate due to weakness, related to pneumonia. The note identified R11's normal gait as shuffling, with the ability to ambulate only short distances while receiving extensive assistance from two staff. A therapy evaluation was indicated for strengthening. Review of a PT evaluation dated 12/30/13, directed R11 was to be seen three times weekly for treatment. On 1/8/14, R11 was discontinued from PT services with recommendations which included initiation of an active assist/passive range of motion (AA/PROM) program for his upper and lower extremities for ten repetitions, with right heel cord and hamstring stretches. R11's plan of care (POC) dated 1/4/14, indicated R11 was to receive strengthening exercises with an exercise group, three times weekly. A 1/14, Rehabilitation Data sheet indicated R11 was to participate in an exercise group, three times weekly; however, a 1/20/14 notation on the data sheet indicated R11 had not attended the exercise group from 1/1/14, through 1/23/14. During interview on 1/22/14, at 10:30 a.m. nursing assistants (NA)-A and NA-B stated R11 did not ambulate and he was not on their list for receiving ROM services.	F 318		

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	245614	A. BUILDING _____ B. WING _____	01/23/2014

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F 318	Continued From page 14 On 1/23/14, at 10:00 a.m. the director of nursing (DON) verified the PT's recommendations for R11 had not been initiated and R11 was not receiving ROM to all four extremities with right heel cord and hamstring stretches. The facility's Nursing Rehabilitation & Restorative Care Program policy dated 5/03, indicated the function of the rehabilitation program was to provide restoration, improvement, or maintenance of the resident's optimal level of function, independence, and quality of life. The policy indicated a resident would be placed on a rehabilitation program following an evaluation from the physical therapist. R20's right-knee brace was not applied as recommended and PT was not consulted when R20 demonstrated resistance toward use of the brace. R20's undated Problem List identified diagnoses including dementia and osteoarthrosis. The 11/7/13, MDS indicated R20 had a cognitive impairment, required extensive assistance with most ADLs, was non-ambulatory, and had impaired right-lower extremity ROM. Review of a 10/11/13, PT evaluation indicated R20 had a contracture of the right knee. On 1/14/14, R20 was discontinued from PT services with recommendations for continued use of a brace to his right-lower extremity which was to be applied at night and while in bed, to decrease the risk for further ROM loss to his right knee. Review of an 11/7/13, MDS note indicated R20	F 318		

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F 318	Continued From page 15 had been assessed by PT and a positioning device was being used to prevent further contracture, which was to be used at night or when in bed. R20's POC dated 1/5/14, lacked notation of R20's contracture and brace. During observation on 1/23/14, at 7:30 a.m. NA-A and NA-B assisted R20 out of bed with a mechanical lift. NA-A attempted to straighten/extend his right knee/lower leg to the bed but was unable. R20 was transferred into the wheel chair. At that time, NA-A again attempted to extend the right knee/lower leg. NA-A was able to partially extend the right knee/lower extremity. NA-A then stated R20's leg was very tight and referred to a brace that was on the floor. NA-A indicated they had been using the brace on R20's right knee/ leg while he was in bed; however, NA-A added, it had been over a month since R20 had worn the brace, because he did not like it and he refused to keep it on. On 1/23/14, at 12:55 p.m. the DON stated the NAs should have attempted to apply the brace and confirmed she was unaware the brace was not being applied. The DON stated she needed to contact PT regarding the brace, given R20's reluctance to use it. The facility's Knee Brace Application procedure dated 1/14, indicated knee brace application was necessary to maintain positioning, provide support, or minimize pain. The procedure noted to apply the brace as ordered and if skin irritation is noted, report the concern to nursing.	F 318		

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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 assess residents for the safe use of bilateral bedrails, for 1 of 1 resident (R9) reviewed with multiple falls and attempts to crawl out of bed. Findings include: R9's quarterly Minimum Data Set (MDS) dated 12/12/13, revealed she was cognitively intact and her diagnoses included Huntington's Chorea (a neurodegenerative genetic disorder effecting muscle coordination, resulting in abnormal involuntary movements). Review of a physician progress note dated 3/6/13, indicated R9 was at severe risk for falls, with a lack of coordinated movement to her upper and lower extremities, and her upper body strength decreased. R9's medical record identified fall reports and intervention notes, which lead to the installation of bedrails to her bed on 10/24/13. These reports included the following: On 10/22/13, at 8:00 a.m. a fall report noted R9 was found on her right side, with her head at the	F 323	See attached plans of correction.	

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F 323	Continued From page 17 foot of her bed and her legs partially under the bed. R9 reported she was looking for her call light. R9 had two call lights, one on each side of the bed. The registered nurse (RN) post fall assessment indicated a decision was made with R9's power of attorney, which included implementation of a low bed with mats, due to spastic movements and poor decisions. On 10/24/13, a nursing progress note read, "Spoke with resident's sister she stated she wanted full side rails to keep the resident in bed. Discussed resident's poor decisions and possibly seeing side rails as a challenge. Compromise reached by giving resident a low bed with mats to prevent injury due to self-transfers, or climbing out of bed. Resident has spastic movements so a low bed with mats would be safer than rails or contour mattress. Maintenance slip made out to switch bed and administrator notified." A maintenance work slip dated 10/24/13, completed by the director of nursing (DON) indicated R9 needed a low bed with mats for safety. The maintenance slip read, installed low bed with rails, put mats on each side of the bed as well. Additional fall reports and intervention notes post application of the bedrails revealed subsequent falls where R9 attempted to crawl or rolled out of bed and notes which referenced R9's use of bedrails as a fall intervention. These reports included the following: On 11/9/13, at 6:20 a.m. a fall report noted R9 rolled out of bed, with her blankets wrapped around her legs. On 12/8/13, at 8:30 a.m. a fall report noted staff found R9 sitting on the mat, on her floor, to the right side of bed. R9 stated she crawled out of	F 323		

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F 323	Continued From page 18 bed to get to the commode. On 12/12/13, MDS notes completed by the DON revealed R9 had sustained five falls since her admission and all falls occurred at bedside. One fall occurred when R9 rolled out of bed. A low bed, with rails and mats on either side of bed were put in place to prevent injury from crawling out of bed. On 12/20/13, at 11:45 p.m. a fall report noted staff heard a noise and found R9 tangled in her covers on the floor, partially off the mat. R9's medical record lacked an assessment to ensure the use of bedrails was safe and appropriate for R9. R9 was in bed, with bilateral, half bedrails in the up position during the following observations: 1/21/14, at 4:02 p.m. 1/22/14, at 9:40 a.m., 10:28 a.m. and 11:40 a.m. 1/23/14, at 7:26 a.m. On 1/23/14, at 11:41 a.m. the DON confirmed there was no bedrail safety assessment completed for R9. The DON stated she had not intended for R9 to have bedrails on her bed. She indicated all reports and notes above, which referenced R9 had bedrails, were inaccurate. On 1/23/14, at 12:43 p.m. the administrator stated maintenance installed a low bed with rails and put mats on each side of R9's bed. The administrator indicated they mistakenly assumed the new maintenance employee knew not to have rails on the bed. The undated Bed Rail Policy & Procedure indicated a resident assessment would be	F 323		

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F 323	Continued From page 19 completed before a bed rail was utilized.	F 323		
F 329 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure adequate sleep monitoring was conducted related to the use of Benadryl (an antihistamine) to treat insomnia and failed to ensure the physician reassessed the continued use and provide an appropriate	F 329	See attached plans of correction.	

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F 329	Continued From page 20 diagnosis for the use of Omeprazole (a proton pump inhibitor) for 1 of 5 residents (R9) whose drug regimen was reviewed. The facility also failed to assess insomnia prior to the initiation of multiple medications to treat insomnia for 1 of 5 residents (R23) whose drug regimen was reviewed. In addition, the facility failed to attempt a tapering dose reduction or provide a clinical rationale for the continued use of an antidepressant for 1 of 5 residents (R22) whose drug regimen was reviewed. Findings include: R9's Facility Problem List indicated R9 had insomnia. R9's quarterly Minimum Data Set (MDS) dated 12/2/13, indicated R9's had Huntington's Chorea (a neurodegenerative genetic disorder that affects muscle coordination causing abnormal involuntary writhing movements). The MDS also indicated R9 was cognitively intact. R9's current physician's order dated 11/18/13, indicated Benadryl 25 milligrams (mg) one capsule at bedtime. However; the original order dated 9/5/13, read Benadryl 25 mg one capsule at night as needed (prn) for sleep. The orders also indicated Omeprazole 20 mg daily. A diagnosis was not identified for the use of the Omeprazole. R9's medication administration record (MAR) for September 2013, indicated the Benadryl was to be given prn. However; R9's October, November,	F 329		

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F 329	Continued From page 21 December 2013, and January 2014, MAR indicated the Benadryl was ordered to be administered nightly. On 1/22/14, at 2:00 p.m. the director of nursing (DON) stated R9 was taking the Benadryl for trouble sleeping at night. In addition, the DON stated R9 was admitted to the facility with an order for Omeprazole 20 mg daily. The DON verified she was unable to find a diagnosis for the Omeprazole use in R9's clinical record. The DON stated she would call the clinic to obtain a diagnosis. At 2:03 p.m. the DON stated the original Benadryl order on 9/5/13, was prn for sleep. The DON stated when she had placed the order in the computer it was transcribed incorrectly. The DON verified the Benadryl was written correctly on the September MAR as prn, and from 10/1/13, through present R9 had incorrectly received the Benadryl nightly. The DON also stated a sleep diary had not been completed for R9. The DON confirmed the Benadryl was ordered prn only so staff could determine R9's actual need. The DON was unable to find a facility policy regarding resident sleep monitoring. Additionally, the DON stated normally staff would monitor a residents sleep pattern for 3 nights and then evaluate the effectiveness of the medication. The DON also verified R9's clinical record lacked documentation by the physician regarding the continued use / rationale for the Omeprazole use. On 1/23/14, at 10:50 a.m. the DON stated she had received a fax from the physician with a diagnosis of GERD (gastrointestinal esophageal reflux disease) for the use of the Omeprazole.	F 329		

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F 329	Continued From page 22 The DON stated the diagnosis had never been addressed in the clinical record. At 2:02 p.m. the pharmacist was interviewed via phone. The pharmacist stated normally he would have looked for sleep monitoring as well as for a diagnosis for Omeprazole and had not. The facility Psychotropic Drug Policy dated 7/9/03, indicated a systematic interdisciplinary process would be used prior to the use of any psychotropic medication and method to ensure continued use is appropriate. R23 received three different medications for sleep induction daily and had not been comprehensively assessed for insomnia prior to their initiation. R23's diagnoses included chronic kidney disease requiring hemodialysis, high blood pressure, depression, sleep apnea and vitamin D deficiency. R23's current physician orders dated 1/3/14, indicated R23 received Xanax 0.5 mg, Ambien 10 mg and melatonin 3.0 mg nightly for sleep. R23's clinical record lacked a comprehensive assessment related to R23's insomnia. R23's monthly pharmacy drug regimen reviews from 8/13. through 1/14, lacked identification the pharmacist had identified R23 had used 3 separate medications for sleep without having a comprehensive assessment of insomnia symptoms. However, on 9/5/13, a pharmacist noted "We have tried [decreasing] dose of	F 329		

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F 329	Continued From page 23 Ambien and Xanax and he gets very angry because he can't sleep. Finally stable on this at least." On 1/22/14, at 3:01 p.m. the DON confirmed R23 had not been assessed for factors related to insomnia and interventions including non-pharmacological interventions had not been developed. R22's facility problem list dated 2/8/13, indicated R22 was diagnosed with depression. R22's quarterly MDS dated 11/29/13, indicated R22 was cognitively intact and expressed little interest or pleasure in doing things, feeling down/depressed or hopeless, had trouble falling or staying asleep or sleeping too much, feeling tired or having little energy, felt bad about self, was a failure or let self or family members down and had trouble concentrating on things such as reading the newspaper or watching television, nearly every day R22's current physician orders dated 12/27/13, indicated fluoxetine hydrochloride (an antidepressant) 20 mg once a day was started on 6/27/13. R22's The Consultant Pharmacist's Medication Review dated 11/22/13, suggested consideration of a reduction in dose of fluoxetine hydrochloride or request the physician list the risks and benefits of the current dose. In addition the review note indicated the pharmacist asked that the request be reviewed with R22's physician during the next visit but no later than two months. R22's clinical record lacked further documentation related to the follow up of the pharmacist's recommendation	F 329		

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F 329	Continued From page 24 On 1/23/14, at 1:53 p.m. The DON confirmed R22's use of fluoxetine hydrochloride was not assessed for dose tapering nor had a rationale for continued use of current dose of the medication documented. The Psychotropic Drugs policy dated as reviewed 12/07 indicated all residents who receive psychotropics (term for psychiatric medicines that alter chemical levels in the brain which impact mood and behavior) will have attempts made periodically to reduce doses and possibly discontinue the drugs unless clinically contraindicated. It further indicated the director of nursing is responsible for adherence to psychotropic protocol.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to administer medications without errors for 2 of 7 residents (R23, R5) whose medication administration was observed which resulted in an error rate of 6.7%. Findings include: On 1/21/14, at 5:12 p.m. during the medication pass observation, the director of nursing (DON) was observed to administer Renvela (a	F 332	See attached plans of correction	

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F 332	Continued From page 25 medication to control phosphorus in patients with chronic kidney disease) 800 milligrams (mg), two capsules, to R23. R23's current physician's order dated 11/21/13, indicated Renvela, one capsule, three times daily with meals. On 1/23/14, at 11:16 a.m. the DON identified in R23's clinical record the original physician's order dated 4/24/13, was for Renvela, one capsule, three times daily with meals; however, on 6/6/13, the order was changed to Renvela 800 mg, two capsules, three times daily with meals. The DON stated when the new physician's order was obtained on 6/6/13, it was never updated in the computer. The DON indicated R23's current physician's order was transcribed in error and was supposed to read Renvela, two capsules, three times daily with meals. On 1/23/14, at 7:01 a.m. licensed practical nurse (LPN)-B was observed to administer Celexa (an antidepressant) 10 mg, to R5. Upon review of the medication administration flow sheets from 11/1/13, through 1/23/14, revealed R5 had received Celexa 10 mg, daily. R5's current physician's order dated 12/31/13, indicated Celexa 10 mg, every other day. On 1/23/14, at 10:55 a.m. the DON verified R5's Celexa order indicated Celexa was to be administered every other day. The DON confirmed R5's Celexa was not administered as ordered and stated it was transcribed incorrectly on R5's medication administration flow sheet.	F 332		
F 334	483.25(n) INFLUENZA AND PNEUMOCOCCAL	F 334	See attached plans of correction	

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F 334 SS=D	Continued From page 26 IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is	F 334		

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HILLCREST SENIOR LIVING	311 BROADWAY AVENUE NE RED LAKE FALLS, MN 56750

(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 334	Continued From page 27 medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the influenza vaccination was administered during the 2013/2014, influenza season or contraindication/refusal was documented in the medical record for 1 of 5 residents (R5) reviewed for immunizations. Findings include:	F 334		

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F 334	Continued From page 28 R5's Resident Admission Record indicated he was admitted prior to the 2013/2014, influenza season. Review of R5's medical record lacked documentation of contraindication, refusal or administration of the influenza vaccination for the 2013/2014 influenza season. On 1/23/14, at 2:26 p.m. licensed practical nurse (LPN)-A confirmed she was unable to locate documentation in R5's record regarding administration, refusal or contraindication of the influenza vaccination. On 1/23/14, at 1:46 p.m. director of nursing (DON) confirmed there was no documentation of the influenza vaccination having been administered, contraindicated or refused for R5. The DON verified the most recent influenza immunization recorded in R5's primary care physician office was 10/12. The facility's Immunization/Vaccination (Resident) policy dated 2/14/08, directed, "Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period."	F 334		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371	See attached plans of correction.	

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F 371	Continued From page 29 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper functioning of their dishwasher in accordance with the manufacturer's instructions, in order to minimize the potential for food borne illness. This had the potential to affect 14 of 15 residents whose meals were served or prepared in the facility kitchen. Findings include: During the initial kitchen tour on 1/21/14, at 11:49 a.m. with dietary aide (DA)-B, a low temperature, chemical sanitizing dishwasher was being used. DA-B stated she did not know what the final rinse temperature of the dishwasher was expected to be for proper sanitation. During observation on 1/22/14, at 9:25 a.m. DA-A ran a load of dishes through a dishwasher cycle. The final rinse temperature of the dishwasher was noted as 100 degrees Fahrenheit (F). DA-A stated the dishwasher had not been used for a while, so she always ran the dishes through twice. As the dishes ran through a second cycle, the final rinse temperature reached 116 degrees F. Upon report of the temperature to DA-A, she ran the dishes through a third cycle. The final rinse temperature of the third cycle reached 120 degrees F. DA-A stated the facility's dishwasher	F 371		

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F 371	Continued From page 30 was old and she did not know what the final rinse water temperature was supposed to be. She added, she did not believe her co-workers were aware of what the expected final rinse temperature was for proper sanitation. On 1/23/14, at 8:39 a.m. DA-A placed a load of cooking utensils through the dishwasher and stated it was the first load of the day. The final rinse temperature was 90 degrees F. DA-A then took the cooking utensils off the dish rack and placed them on a tray to air dry. A second load of dishes ran through the dishwasher, with a final rinse temperature of 106 degrees F. Upon notification of the observed final rinse temperature, DA-A ran the dishes through again. The final rinse temperature was 118 degrees F. DA-A reported that silverware was routinely run through the dishwasher twice; however, the dishes were not always put through a second time. DA-A then ran the dishes through a third cycle, with the final rinse temperature of 122 degrees F, which was verified by DA-A. On 1/23/14, at 12:25 p.m. the administrator confirmed the facility's dietary manager was not available for interview. The administrator added that he was not aware of the final rinse temperatures for the dishwasher. He added the dishwasher was old. The manufacturer's guide for the facility's dishwasher dated 2009, indicated the sanitizing rinse temperature was supposed to reach 120 degrees F.	F 371		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428	See attached plans of correction.	

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F 428	Continued From page 31 The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the physician and the director of nursing (DON) acted upon the pharmacy recommendations for 2 of 5 residents (R9, R22) in the sample reviewed with pharmacy recommendations. In addition, the pharmacist failed to report to the physician and director of nursing the initiation of multiple medications being used to treat insomnia for 1 of 5 residents (R23) lacking a pharmacy recommendation. Findings include: R9's Problem List identified a diagnosis of insomnia. R9's quarterly Minimum Data Set (MDS) dated 12/12/13, indicated R9 was also diagnosed with Huntington's Chorea (a neurodegenerative genetic disorder that affects muscle coordination causing abnormal involuntary writhing movements). The MDS also indicated R9 was cognitively intact. R9's current physician's order dated 11/18/13,	F 428		

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F 428	Continued From page 32 indicated an order for Benadryl (an antihistamine) 25 milligrams (mg) one capsule at bedtime and Omeprazole (proton pump inhibitor) 20 mg daily. R9's clinical record revealed the pharmacist had submitted a recommendation in September 2013, requesting the physician to change the Benadryl to Melatonin (a hormone supplement for sleep). In addition, the pharmacist also made a recommendation in November 2013, requesting the physician to reassess the need for Omeprazole. On 1/22/14, at 2:03 p.m. the DON stated the pharmacy recommendation for September 2013, had not been faxed to the physician for review nor was there documentation to indicate the physician had received the November 2013, pharmacy recommendation. The DON confirmed the pharmacy recommendations were not acted upon. The undated drug regimen review policy indicated drug irregularities will be questioned each time they are encountered with supporting documentation. R23 received three medications for sleep daily, and had not been comprehensively assessed for insomnia prior to their initiation. In addition, the	F 428		

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F 428	Continued From page 33 consultant pharmacist had not identified this irregularity. R23's diagnoses included chronic kidney disease requiring hemodialysis, high blood pressure, depression, sleep apnea and vitamin D deficiency. R23's current physician orders dated 1/3/14, indicated R23 received Xanax 0.5 mg nightly for sleep, Ambien 10 mg one tab nightly for sleep induction and melatonin 3.0 mg every night for sleep. R23's clinical record lacked a comprehensive assessment of R23's insomnia symptoms. R23's monthly pharmacy drug regimen reviews from 8/13-1/14, were reviewed and the pharmacist had not identified R23 had used 3 different medications for sleep induction without having a comprehensive assessment of insomnia symptoms. On 9/5/13, a pharmacist had noted "We have tried [decreasing] dose of Ambien and Xanax and he gets very angry because he can't sleep. Finally stable on this at least." On 1/22/14, at 3:01 p.m. the DON confirmed R23 had not been assessed for factors related to insomnia nor had interventions including non-pharmacological interventions had been developed. On 1/23/14, at 2:30 p.m. the consultant pharmacist stated he could not look at each residents assessments to ensure they were completed prior to the initiation of a hypnotic medication. The consultant pharmacist stated he	F 428		

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F 428	Continued From page 34 felt it was a given that nursing completed their assessments. R22 received a daily antidepressant without a gradual dose reduction or clinical rationale for continued use. R22's facility problem list dated 2/8/13, indicated R22 was diagnosed with depression. R22's quarterly MDS dated 11/29/13, indicated R22 was cognitively intact and expressed little interest or pleasure in doing things, feeling down/depressed or hopeless, had trouble falling or staying asleep or sleeping too much, feeling tired or having little energy, felt bad about self, was a failure or let self or family members down and had trouble concentrating on things such as reading the newspaper or watching television, nearly every day R22's current physician orders dated 12/27/13, indicated fluoxetine hydrochloride (an antidepressant) 20 mg once a day was started on 6/27/13. R22's The Consultant Pharmacist's Medication Review dated 11/22/13, suggested consideration of a reduction in dose of fluoxetine hydrochloride or request the physician list the risks and benefits of the current dose. In addition the review note indicated the pharmacist asked that the request be reviewed with R22's physician during the next visit but no later than two months. R22's clinical record lacked further documentation related to the follow up of the pharmacist's recommendation On 1/23/14, at 1:53 p.m. the DON confirmed the	F 428		

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F 428	Continued From page 35 facility did not have new orders for dose tapering nor rationale for continued use of current dose of the medication. On 1/23/14, at 2:20 p.m. the consulting pharmacist confirmed there had been no facility response to the 11/22/13, request for dose reduction or rationale/benefit of use documentation for R22's fluoxetine hydrochloride medication. The undated Drug Regimen Reviews policy indicates if stated objectives are apparently not being achieved, and/or potential problems are detected the attached "Physician Report of Drug Regimen Review" form will be completed and mailed to the MD for review and/or action.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441	See attached plans of correction.	

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F 441	Continued From page 36 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control program that included comprehensive surveillance of resident and employee illnesses and infections, analysis of the surveillance and investigation of patterns identified through the analysis. This had the potential to affect all 15 of 15 residents who resided in the facility. Findings included: Review of the facility's infection control program revealed a system which lacked a surveillance program with ongoing analysis and interpretation of infections and infection risks. The monthly Infection Control Logs for 10/13, 11/13, 12/13, and 1/14, revealed only infections with prescribed	F 441		

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F 441	Continued From page 37 antibiotics were tracked. Identification of the infectious organism and specific symptoms were lacking. The facility's tracking system also lacked trending of infections without antibiotics. In addition, a tracking system for employee infections and comparison surveillance between resident and employee illnesses had not been established. On 1/23/14, at 1:45 p.m. the facility infection control program was reviewed with the director of nursing (DON). DON indicated when an antibiotic was ordered for a resident, the floor nurse entered the resident's name on the Infection Control Log, along with the date, type of infection, and antibiotic prescribed. If the resident was on continued antibiotics or if an infection had not resolved, the floor nurse contacted the physician for further orders. DON indicated infections without a prescribed antibiotic were sometimes noted on the infection control log; however, she added this was not done on a consistent basis. The facility's monthly Infection Control Logs were reviewed by the DON quarterly and the information was compiled into a report which was reviewed and discussed by the facility's Quality Assurance and Assessment (QAA) committee. DON also stated a similar process for employee infections was to take place, but she had not had the time to complete the work. DON stated she received an Employee Call-In Report form for each employee illness. The information from this form was to be entered into a log for quarterly tracking, similar to the system for resident infections. She indicated a book for tracking employee infections was started in 2/13, but she had not had a chance to evaluate the information for the quarterly reports.	F 441		

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F 441	Continued From page 38 The DON reported that if increased infections were noted, the information was shared at shift report; however, she confirmed there was no formalized process for review or analysis of the data more frequently than her quarterly QAA report, nor was there a process to correlate employee and resident infections/illnesses. Review of the facility policy titled Infection Survalence [sic] of Employees, dated 3/20/12, indicated the name of employees, the date and brief symptoms of employee illness were to be recorded into the Employee Illness/Injury Record and reviewed on a weekly basis by the interdisciplinary team, to identify patterns, reoccurring infections/illnesses and to determine any risk to the residents. Review of the facility policy titled Infection Control Program, dated 3/31/11, lacked direction for how the facility was to develop, implement, or maintain an infection control program in order to prevent, recognize/control, to the extent possible, the onset and spread of infection within the facility.	F 441		

F156:

1. Resident R19: Has been discharged.

Resident R1: Record has been reviewed with appropriate formats in place

2. All resident records have been reviewed/audited and are currently in compliance with notification notices.

3. Clinical team members, responsible for appropriate denial notices have been educated on the regulatory requirements of proper resident notices.

4. As resident status changes with regards to compensable services, Social Service designee or other designee shall audit the record to assure appropriate forms are implemented and protocols for notifications are timely. Audit outcomes shall be reported to QAA Committee for review &/or comment.

5. Date for correction: 3/4/2014

F242:

1. R1: Preferences have been addressed and schedule care plan updated as needed.

R22: Has been discharged.

2. All resident records have been audited to note resident bathing preferences with follow-up interviews as able, to confirm accurate bathing preferences. Further audits of all records will be completed to assure care plan and NA/R care sheet documents record the preferences.

3. All staff responsible for providing resident care will be educated on following the resident's plan of care and to report refusals and/or preference changes.

4. DON or designee shall audit all care sheets weekly X4 weeks, then, at least bi-monthly X60 days to assure cares are provided as directed. These audit outcomes shall be reported to the QAA committee for review &/or comment.

5. Date of correction: 3/4/2014

F280:

1. R11: has been discharged.

2. All resident records have been audited to assure recommended rehab modalities are accurately documented in the plan of care and NA/R flow-sheets.

3. All staff responsible for providing rehab modalities have been educated on the individual protocols and documentation standards.

4. DON or designee shall audit nursing rehab flow-sheets at least weekly X4 weeks, then, bi-monthly X60 days to assure ongoing compliance. Audit outcomes shall be reported to the QAA committee for comment & review.

5. Date of completion: 3/4/14.

F282:

1. R5: Has been discharged.

2. All resident records have been reviewed to assure ambulation modalities are appropriately care planned and documented.

3. All staff responsible for ambulation modalities have been educated on individual resident rehab modalities including ambulation including accurate documentation.

4. DON or designee will audit all records weekly X4 weeks, then, bi-weekly X 60 days to assure ongoing rehab & ambulation modalities are accurately & consistently recorded as ordered. Audit outcomes shall be reported to the QAA committee for comment & review.

4.5 A list of all residents receiving ambulation shall be maintained by the Director of Nursing and will be review daily to ensure that all resident requiring ambulation are ambulated according to care plan.

5. Date of Correction: 3/4/14

F311: Please refer to F282:

1. R5: Has been discharged.

F318:

1: R11: Has been discharged.

R20: Interventions have been reviewed & are current.

2. All resident records have been reviewed to assure recommended rehab modalities are recorded, care planned and implemented as recommended.

3. All staff providing those modalities have been educated on the modalities and accurate documentation.

3.5 Staff members have been educated to report to the charge nurse if a resident refuses rehab modalities.

4. DON or designee shall audit all records weekly X4 weeks, then, bi-weekly X 60 days to assure ongoing compliance with implementation as well as current care plans of rehab modalities and/or prosthetic devices. Outcomes shall be submitted to the QAA committee for comment & review.

5. Date for correction: 3/4/14.

F323:

1. R9: Does not require side rails.

2. All unusual occurrence reports, including falls, have been reviewed for root cause analysis. Additionally, all residents utilizing assistive devices, including side rails, have had their records reviewed for current assessments, accurate care planning and appropriate utilization.

3. All staff providing resident care will be educated on the use & documentation of ordered assistive devices.

4. DON or designee shall audit resident records weekly X2 then, bi-monthly X 60 days to assure ongoing compliance with the interventions and documentation. Audit outcomes shall be reported to the QAA committee for review & comment.

5. Date of Correction: 3/4/14.

F329:

1. R9: Her use of Benadryl and his omeprazole have been addressed.

R23: Residents record has been reviewed and assessments being completed.

R22: Has been discharged.

2. All resident MD orders have been reviewed and compared to transcribed orders to assure accuracy of the transcription. Furthermore, all residents on psychoactive meds have been reviewed to assure appropriate target behaviors are documented on the plan of care & are being monitored with appropriate, timely analysis including assessment data, in particular sleep diaries. Current RPh recommendations have also been reviewed to assure all residents have been reviewed for medication use & that those recommendations have been communicated to the DON & primary MD.

3. All staff administering medications, including psychoactive meds have been educated on protocols to monitor & track behaviors. All staff have been educated on the need to report & document observed resident changes & target behaviors .

4. DON or designee shall audit resident records weekly X4 weeks, then, bi-monthly for 60 days to assure all medication administration entries are accurate and reported behaviors are recorded per protocols. Additionally, social service designee shall assure monthly summaries, quantitatively & qualitatively discuss target behaviors in relation to the psychoactive medication. All audit outcomes shall be presented to the QAA committee for review &/or comment.

5. Date of Correction: 3/4/14.

F332:

1. R23: His orders have been reviewed and reflect current MD orders.

R5: Has been discharged

2. See F329:

3. See F329

4. The DON or designee shall do observational audits of all staff that administer medications weekly X1 week. Then, bi-monthly X60 days to assure compliance with accurate administration. All audit outcomes shall be reported to the QAA committee for review &/or comment.

5. Date of completion: 3/4/14.

F334:

1. R5: Has been discharged.

2. All resident records have been audited to assure immunizations are administered as needed with requisite risk/benefit documentation present.

3. & 4. DON or designee will audit all records to assure immunization documentation is accurate and timely and contain risk/benefit of the immunization. Audit info shall be reported to the QAA committee for review.

5. Date of completion: 3/4/14.

F371:

1. Maint. has increased heat temp at heat source with multi-temps being taken throughout the day.

2. Dietary personnel have been educated on the temp taking protocols and the need to report unacceptable dishwasher temps.

3. Director of Maint./Adm. will monitor dailyreports for compliance & report audit outcomes to the QAA committee for review & comment.

4. Date for Correction: 3/4/2014

F428:

1. R9 and R23: Residents orders have been reviewed and assessment data will be available for the RPh to review.

R22: Has been discharged.

2. See F329.

3. See f329

4. See F329

5. Date of completion: 3/4/14.

F441:

1.

2. Policy & procedure of tracking & trending staff/resident infections have been reviewed and updated as needed.

3. All staff who take staff call-ins and note resident infections have been educated on the protocols of tracking possible infectious processes. The Facility infection control nurse shall track & trend all resident & staff infections and graphically detail those infections as well as provide a narrative of the possible or lack of possible correlation between the two.

4. Daily, the DON or designee shall review staff calls to note illness SX. and document. Also, daily, the DON shall review daily documentation to monitor any potential infectious processes and record per protocol. Monthly, the DON shall track & trend all infections and provide preventive interventions as needed. Quarterly, the DON shall perform an analysis of the data to be presented to the QAA committee for review & comment.

5. Date for Completion: 3/4/14.

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

F5614006

PRINTED: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245614	A. BUILDING 01 - MAIN BLDG B. WING _____	01/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST SENIOR LIVING	311 BROADWAY AVENUE NE RED LAKE FALLS, MN 56750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN 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. At the time of this survey Hillcrest Senior Living 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 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 Or by e-mail to:	K 000	POC ok 3-14-14 RECEIVED MAR 12 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 3-4-14

EXIT: 1-23-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mike Bu

TITLE: Administrator

(X6) DATE: 2/28/14

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.u Fax Number 651-215-0525 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 Hillcrest Senior Living was built at two different times. The original building was constructed in 1959, is 1-story without a basement and was determined to be of a Type II(111) construction. In 1966 the north wing addition was built. It is 1-story with a basement, was determined to be of a Type II (111) construction. The building is divided into 4 smoke zones by fire barriers of at least 30 minutes. The building has an automatic sprinkler systems installed in accordance with NFPA 13 Standard for the installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection throughout the corridor system and in the common spaces installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition and is monitored for automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the	K 000		

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K 000	Continued From page 2 Minnesota State Fire Code 2007 edition. The facility has a capacity of 30 beds and had a census of 15 at the time of the survey. The facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on a review of fire drill records, it was determined that the facility staff have not conducted fire exit drills in accordance with National Fire Protection Association (NFPA) 101 "The Life Safety Code" (LSC) 2000 edition section 19.7.1.2. Not conducting fire exit drills could allow confusion and delay in the staff response, which would negatively impact all 45 of the residents and any visitors in a fire emergency. Findings include: A review of the fire exit drill records for Hillcrest	K 050	See attached plans of correction.	

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K 050	Continued From page 3 Senior Living for 2013, prior to the facility tour on January 22, 2014, at approximately 9:4:5 am, by surveyor 03006, revealed that fire drills have not been conduct on the day shift in the 2nd and 3rd quarters of 2013. This finding was verified by the Administrator during the facility tour and during the exit conference.	K 050		
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Observations revealed that the facility staff have maintained the exit discharges so they are available for the full and instant use in an emergency which is required by NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 7.1.10.2.1. This deficient practice can slow or even prevent exiting effecting 15 of the 30 residents, any staff and visitors of the wings effected. Findings include: During the facility tour on January 22, 2014, between 10:00 am and 11:45 am, observations by surveyor 03006 revealed that snow has blown in on the east exit discharges (the exit doors can be opened easily) and has not been removed to	K 072	See attached plans of correction.	

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K 072	Continued From page 4 a public way. This finding was verified by the Administrator during the facility tour and during the exit conference.	K 072		

Hillcrest Senior Living Life Safety Code Plans of Correction

K050 Maintenance Director and Social Services Designee have been re-educated on the need to conduct fire drills at least monthly and that fire drills rotate by shift each month such that all 3 shifts have a fire drill each quarter. Administrator will audit fire drill records monthly to ensure fire drills completed accurately.

Completion Date: 3/4/2014

K072 Maintenance Director has been re-educated on the need to maintain sidewalks from exit discharges such that snow does not hinder the ability of staff and residents to exit the building to the public way. Administrator and/or Social Services shall audit the condition of sidewalks 5x'week through May 1, 2014

Completion date: 3/4/2014