DEPARTMENT OF HEAD	LTH AND HUMA	N SERVICES			CENTERS FOR ME	DICARE & MEDICAID SERVICES
	MEDICA	ARE/MEDICAL	D CERTIFIC	CATION A	AND TRANSMITTAL	ID: R7NS
	PART I -	TO BE COMPI	LETED BY T	HE STAT	TE SURVEY AGENCY	Facility ID: 00407
1. MEDICARE/MEDICAID PRO NO.(L1) <b>245395</b>	VIDER	3. NAME AND AI (L3) <b>CROSSROA</b>	ADS CARE CE	NTER		4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification
2. STATE VENDOR OR MEDICA (L2) <b>146319500</b>	AID NO.	(L4) <b>965 MCMIL</b> (L5) <b>WORTHING</b>		ſ	(L6) <b>56187</b>	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANGE (L9)	OF OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEG 05 HHA	ORY <b>09 ESRD</b>	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
<ol> <li>6. DATE OF SURVEY</li> <li>8. ACCREDITATION STATUS:</li> </ol>	<b>0/26/2017</b> <sup>(L34)</sup> (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Oth		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
11LTC PERIOD OF CERTIFICAT	TION	10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b):		U U	equirements		2. Technical Personne	6. Scope of Services Limit
		Compliance	e Based On:		3. 24 Hour RN	7. Medical Director
10 T-4-1 E114- D-4-	<b>50</b> (119)	1. A	cceptable POC		4. 7-Day RN (Rural SI	NF) 8. Patient Room Size
12.Total Facility Beds	<b>50</b> (L18)				5. Life Safety Code	9. Beds/Room
13.Total Certified Beds	<b>50</b> (L17)	B. Not in Comp Requirements	liance with Progra and/or Applied V		* Code: A	(L12)
14. LTC CERTIFIED BED BREAK	DOWN				15. FACILITY MEETS	
18 SNF 18/19 SI	NF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
50						
(L37) (L38)	(L39)	(L42)	(L43)			
17. SURVEYOR SIGNATURE Wendy Buckholz, H	IFE NE II	Date :	1/14/2017		18. STATE SURVEY AGENCY	
				(L19)	COFFICE OR SINGLE S	alth Program Representative 11/14/2017 (L20)
19. DETERMINATION OF ELIG			IPLIANCE WITH			ancial Solvency (HCFA-2572)
1. Facility is Eligible	to Participate		ITS ACT:			rol Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	-				3. Both of the Abov	
2. Facility is not Eng	(L21)					
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEM	IENT	26. TERMINATION ACTION	I: (L30)
OF PARTICIPATION	BEGINNING	<b>J</b> DATE	ENDING DAT	ΓE	<u>VOLUNTARY</u> 0	0 INVOLUNTARY
01/01/1987					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburg 03-Risk of Involuntary Terminati	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			04-Other Reason for Withdrawal	OTHER
	A. Suspension	n of Admissions:	<i>σ</i> . 40		04-Ould Reason for windrawa	07-Provider Status Change 00-Active
(L27)	B Rescind St	spension Date:	(L44)			00-Active
	D. Resenid St	ispension Date.	(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	. ,		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE		
	(L32)			(L33)	DETERMINATION APP	PROVAL



Protecting, Maintaining and Improvingthe Health of All Minnesotans

CMS Certification Number (CCN): 245395

November 14, 2017

Mr. Scott Kessler, Administrator Crossroads Care Center 965 McMillan Street Worthington, MN 56187

Dear Mr. Kessler:

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

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

Effective October 5, 2017 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>kamala.fiske-downing@state.mn.us</u>

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 14, 2017

Mr. Scott Kessler, Administrator Crossroads Care Center 965 McMillan Street Worthington, MN 56187

RE: Project Number S5395027

Dear Mr. Kessler:

On October 24, 2017, we informed you that the following enforcement remedy was being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 17, 2017. (42 CFR 488.417 (b))

Also, we notified you in our letter of October 24, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 17, 2017.

This was based on the deficiencies cited by this Department for a standard survey completed on August 17, 2017, and lack of verification of substantial compliance with the health deficiencies at the time of our October 24, 2017 notice. The most serious health deficiencies in your facility at the time of the standard survey were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), whereby corrections were required.

On October 26, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 25, 2017 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 August 17, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 20, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 17, 2017, as of October 5, 2017.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of October 24, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

Crossroads Care Center November 14, 2017 Page 2

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 17, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 17, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 17, 2017, is to be rescinded.

In our letter of October 24, 2017, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 17, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 5, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>kamala.fiske-downing@state.mn.us</u>

cc: Licensing and Certification File



Protecting, Maintaining and Improvingthe Health of All Minnesotans

Electronically delivered

November 14, 2017

Mr. Scott Kessler, Administrator Crossroads Care Center 965 McMillan Street Worthington, MN 56187

Re: Reinspection Results - Project Number S5395027

Dear Mr. Kessler:

On October 26, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 17, 2017, with orders received by you on September 13, 2017. At this time these correction orders were found corrected.

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.

Please feel free to call me with any questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>kamala.fiske-downing@state.mn.us</u>

cc: Licensing and Certification File

DEPARTMENT OF HEALT	'H AND HUMA	N SERVICES			<b>CENTERS FOR MEI</b>	DICARE & MEDIC	AID SERVICES
	MEDICA	ARE/MEDICAL	D CERTIFI	CATION A	AND TRANSMITTAL	1	D: R7NS
	PART I -	TO BE COMPI	LETED BY 1	THE STAT	<b>FE SURVEY AGENCY</b>	]	Facility ID: 00407
1. MEDICARE/MEDICAID PROVID NO.(L1) <b>245395</b>	DER	3. NAME AND AI (L3) <b>CROSSROA</b>				4. TYPE OF ACTIO	N: <u>2(</u> L8) 2. Recertification
2. STATE VENDOR OR MEDICAII (L2) <b>146319500</b>	D NO.	(L4) <b>965 MCMII</b> (L5) <b>WORTHIN</b>		Т	(L6) <b>56187</b>	<ol> <li>Termination</li> <li>Validation</li> </ol>	4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEC 05 HHA	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After	9. Other Complaint
6. DATE OF SURVEY <b>08</b> /	17/2017 <sup>(L34)</sup>	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDI	NG DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31	
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	AS:		·	
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirement	ents:
To (b):			equirements e Based On:		2. Technical Personnel	6. Scope of Se	rvices Limit
		-			3. 24 Hour RN	7. Medical Dir	
12.Total Facility Beds	<b>50</b> (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN		n Size
13.Total Certified Beds	<b>50</b> (L17)	X B. Not in Con	npliance with Pro	gram	5. Life Safety Code	9. Beds/Room	
		Requirements	and/or Applied	Waivers:	* Code: <b>B</b> *	(L12)	
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
50							
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Sandra Tatro, HFE N		ſ	9/23/2017				
			19/23/2017	(L19)	Kamala Fiske-Downing, Hea	alth Program Represer	<u>ntative</u> 10/25/2017 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	<b>COFFICE OR SINGLE S</b>	STATE AGENCY	
19. DETERMINATION OF ELIGIBI	LITY		IPLIANCE WIT	H CIVIL		ancial Solvency (HCFA-257	
1. Facility is Eligible to	Participate	RIGI	HTS ACT:		<ol> <li>Ownership/Contr</li> <li>Both of the Above</li> </ol>	ol Interest Disclosure Stmt	(HCFA-1513)
2. Facility is not Eligible							
	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREE	MENT	26. TERMINATION ACTION	[: (	L30)
OF PARTICIPATION	BEGINNINC	<b>J</b> DATE	ENDING DA	TE	<u>VOLUNTARY</u> 00	<u>0</u> <u>INVOLUN</u>	TARY
01/01/1987					01-Merger, Closure	05-Fail to I	Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-PI0VIde	er Status Change
(L27)	D Daraind C	Deter	(L44)			00-Active	
	B. Rescind Si	spension Date:	(1.45)				
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	I OF APPROVAI	LDATE			
				_			
	(L32)			(L33)	DETERMINATION APP	ROVAL	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 3, 2017

Mr. Scott Kessler, Administrator Crossroads Care Center 965 McMillan Street Worthington, MN 56187

RE: Project Number S5395027

Dear Mr. Kessler:

On August 17, 2017, 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 electronically delivered CMS-2567 whereby corrections are required.

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

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

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

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

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

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

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

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

## DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor Mankato Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1400 East Lyon Street, Suite 201 Marshall, Minnesota 56258-2504 Email: kathryn.serie@state.mn.us Phone: (507) 476-4233 Fax: (507) 344-2723

## **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 September 26, 2017, 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 September 26, 2017 the following remedy will be imposed:

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

## ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

Crossroads Care Center September 3, 2017 Page 4

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

#### Original deficiencies not corrected

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

#### Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

## Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 17, 2017 (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

Crossroads Care Center September 3, 2017 Page 5 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 February 17, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

## INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525 Crossroads Care Center September 3, 2017 Page 6

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 Health Regulation Division Minnesota Department of Health Email: <u>mark.meath@state.mn.us</u> Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			MAPPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		OMB N	O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED
		245395	B. WING		8/17/2017
NAME OF F	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE	
CROSSR	OADS CARE CENTE	R		965 MCMILLAN STREET WORTHINGTON, MN 56187	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 COMMENT	ſS	F 000		
	8/14, 8/15, 8/16, an Department of Hea was in compliance Part 483, Subpart E Care Facilities.	was completed at your facility d 8/17/17 by the Minnesota lth to determine if your facility with requirements of 42 CFR 8, Requirements for Long Term			
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve f compliance upon the ptance. Because you are your signature is not required first page of the CMS-2567 ic submission of the POC will tion of compliance.			
F 176 SS=D	on-site revisit of you validate that substa regulations has bee your verification. 483.10(c)(7) RESID	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with DENT SELF-ADMINISTER D SAFE	F 176		9/20/17
	the interdisciplinary §483.21(b)(2)(ii), hapractice is clinically	elf-administer medications if team, as defined by as determined that this appropriate. NT is not met as evidenced			
	Based on observat review, the facility fa had been complete	ion, interview and document ailed to ensure an assessment d for safe self-administration		Resident 46 has had a self-administration of Medications (SAM).	n
	observed self-admi medication.	I) for 1 of 2 residents (R46) nistering a nebulizer		Any other resident affected by this deficient practice had had a Self-Administration of medications (SAM done for them.	)
	Findings include:				
LABORATOR	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE
Electron	ically Signed				09/13/2017

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

PRINTED: 10/23/2017

	OF DEFICIENCIES	<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TI	PLE CONSTRUCTION		0938-039 E SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:	. ,	G		PLETED	
		245395	B. WING			17/2017	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
CROSSR	OADS CARE CENTE	R		965 MCMILLAN STREET WORTHINGTON, MN 56187			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 176	R46's annual Minin assessment dated interview for menta The activities of da all activities as exter mobility, transfer, w locomotion on and and personal hygie eating which was c R46's current phys Suspension 0.5 mil (ml); inhale orally tw idiopathic pulmona lungs that causes p Additionally, R46 al order for DuoNeb S to be given for shor medication adminis medication had bee since 7/1/17. On 8/16/17, at 8:03 enter R46's room to treatment. RN-B fill medication, and ha then stated to the s nebulizer and the re responsible to keep R46 was observed face while the nebu- left the room to cor pass. Several minit	num Data Set (MDS) 6/14/17, indicated a brief al status (BIMS) score of 12, ily living assessment identified ensive assistance (bed valk in room and corridor, off unit, dressing, toilet use ne) with the exception of oded independent. ician orders included Pulmicort lligrams (mg) per 2 milliliters wo times a day related to ry fibrosis (scar tissue in the orogressive damage). Iso received an as needed Solution 0.5-2.5; 3 mg per 3 ml, rtness of breath, the stration record indicated this en administered three times B a.m. RN-B was observed to o administer a nebulizer led the nebulizer with the anded R46 the mask. RN-B surveyor that she starts the esident will then be o the mask on independently. to hold the mask up to his ulizer treatment began. RN-B ntinue with the medication utes later the RN-B returned to	F 17	<ul> <li>Facility nurses have been new program explained be on the new policy for perfor Self-Administration of Med for residents.</li> <li>The policy for doing Self-A medications (SAM) for resupdated to include doing a residents upon admission other time that it seems ap Director of Nursing or her review each admission aftr completed to ensure that the been completed or else not the admitting nurse that a appropriate. Additionally, a time, where it appears a rest to self-administer medicati will be notified and she, or will ensure that the SAM is nursing.</li> <li>The DON will appoint som nursing management staff SAMs are being done as r admission where appropriate. As well, the admission where appropriate at the seminal staff semina</li></ul>	elow as well as siming lications (SAM) administration of idents has been and at any opropriate. The designee will er it has been he SAM for and at any opropriate. The designee will er it has been he SAM has otation made by SAM is not at any other esident is able ons, the DON her designee, completed by eone from the to ensure that equired upon ate or else is not auditor will audit esidents were dministration of M was done. med weekly x 4		
	the room to remove treatment. At that ti to his face, which h arrived. R46 was h	the nebulizer mask and ime, R46 still had the mask up in removed when the nurse here to state that he thought finished. RN-B verified the		The DON will report month Committee on this program	nly to the QA		

		AND HUMAN SERVICES				FORM	: 10/23/2017 APPROVED
STATEMENT	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY IPLETED
		245395	B. WING	i		08/	17/2017
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CROSSF	ROADS CARE CENTE	R		-	965 MCMILLAN STREET NORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 176	treatment was com nebulizer chamber, and left the mask a paper towels. R46's self-administ 6/7/17, indicated R4 or functional ability medications. In an interview with 8/16/17, at 2:45 p.n and out of the facilit succeed at home". she had completed self-administration resident's readmiss the SAM assessmed determine whether medications and to cognitive ability to p Coordinator further having done any fur ability to conduct se medications since 6 The director of nurs 8/17/17, at 9:45 a.n assessment should R46 being allowed treatment. The facility's policy Medications, indica may self-administer determined they we part of their overall practitioner will ass	plete by examining the she then rinsed the chamber and chamber to air dry on ration assessment dated 46 did not have the cognitive to self-administer his the MDS Coordinator on n. she stated R46 had been in ty due to being "unable to The MDS Coordinator stated the initial brief assessment for of medications following the sion to the facility. She said ent had been conducted to R46 wished to self-administer determine whether he had the perform the task. The MDS stated she could not recall rther assessment of R46's elf-administration of	F	176			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/23/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245395	B. WING _			08/ <sup>,</sup>	17/2017
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CROSSR	OADS CARE CENTE	र			55 MCMILLAN STREET ORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 176	Continued From pa	ge 3	F 17	76			
F 280 SS=D	483.10(c)(2)(i-ii,iv,v	dministering medications." )(3),483.21(b)(2) RIGHT TO NNING CARE-REVISE CP	F 28	30			9/20/17
	and implementation	articipate in the development of his or her person-centered ng but not limited to:					
	including the right to be included in the p request meetings a	cipate in the planning process, o identify individuals or roles to lanning process, the right to nd the right to request son-centered plan of care.					
	expected goals and amount, frequency,	cipate in establishing the outcomes of care, the type, and duration of care, and any d to the effectiveness of the					
	(iv) The right to rece included in the plan	eive the services and/or items of care.					
		the care plan, including the gnificant changes to the plan					
	right to participate in	nall inform the resident of the n his or her treatment and sident in this right. The ust					
	(i) Facilitate the incl resident representa	usion of the resident and/or tive.					
	(ii) Include an asses strengths and need	ssment of the resident's s.					

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245395	B. WING_			08/ <sup>.</sup>	17/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CROSSR	OADS CARE CENTE	R			65 MCMILLAN STREET VORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	Continued From pa	ige 4	F 28	80			
		resident's personal and s in developing goals of care.					
	483.21 (b) Comprehensive	Care Plans					
	(2) A comprehensiv	ve care plan must be-					
	(i) Developed within the comprehensive	n 7 days after completion of assessment.					
	(ii) Prepared by an i includes but is not l	interdisciplinary team, that imited to					
	(A) The attending p	hysician.					
	(B) A registered nur resident.	rse with responsibility for the					
	(C) A nurse aide wit resident.	th responsibility for the					
	(D) A member of fo	od and nutrition services staff.					
	the resident and the An explanation mus medical record if the and their resident re	acticable, the participation of e resident's representative(s). st be included in a resident's e participation of the resident epresentative is determined the development of the n.					
		te staff or professionals in mined by the resident's needs the resident.					
	(iii) Reviewed and r	evised by the interdisciplinary					

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			()(0)		OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	TIPLE CONSTRUCTION		E SURVEY PLETED
		245395	B. WING		08/	17/2017
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIF	CODE	
CROSSR	OADS CARE CENTE	R		965 MCMILLAN STREET WORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE TE APPROPRIATE	(X5) COMPLETIO DATE
F 280	Continued From pa	age 5	F 2	280		
	team after each as comprehensive and assessments.	sessment, including both the				
	Based on observative review, the facility f	tion, interview and document ailed to revise the plan of care		Care plans regarding side reviewed and updated for		
	repositioning/transf	for assistive devices for ferring from bed for 1 of 3 riewed for accidents and who ails.		Any other resident affecte deficient practice, includin residents with side rails, h care plans reviewed and u	g primarily those ave had their	
	Findings include:			necessary.		
	laying in bed with 1 bed in the up positi On 8/16/17, at 3:19	on 8/16/17, at 11:34 a.m. /4 side rails bilaterally on the on. 9 p.m. R37's side rail was position. The director of		Nursing staff and the IDT in-serviced on the necess resident care plans in acc changes and use of their have also been trained on change and the new pract	ity of updating ordance with side rails. They the policy	
	nursing (DON) look	ted the quarter rail on the door		below.		
	side of the bed had significant movement from the bed outward. The DON stated, "this is borderline," referring to safety, and stated she would ask maintenance to see if he could tighten the side rail. Further, the DON stated side rail assessments were completed upon admission, quarterly, and with medication and mobility changes. The DON also stated the side rail should be physically checked for safety with each			The facility policy for side updated to include updatin care plan for the use and rails contemporary with th Additionally, the IDT will re with side rails monthly to e changes in the use of side care planned.	ng any resident purpose of side e use of them. eview residents ensure that any	
	side rail assessmen R37's annual Minin 6/12/17, indicated F had short and long had moderately im MDS also indicated			The DON or her designee plans for residents with sig x3 to ensure compliance y policy stated above after y will take-over that audit fu DON will report monthly to Committee on this program	de rails monthly with the updated which the IDT nction. The o the QA	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/23/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245395	B. WING			08/	17/2017
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CROSSR	OADS CARE CENTE	R			65 MCMILLAN STREET /ORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 280 F 282 SS=E	indicated R37 requi for locomotion on u Area Assessment (f R37 had advanced assistance with acti also indicated R37 at times needed sta unsteadiness. R37's careplan date able to transfer inde and stand by or limi indicated R37 was a bed. However, the o use of a quarter (1/4 During an interview on 8/16/17, at 1:53 required staff assist R37 had demential utilized the quarter a The facility's undate Comprehensive Ca individualized comp includes measurabl meet the resident's psychological needs resident f. Identify are responsible for Reflect currently red for problem areas a Assessments of res plans are revised as resident and the res	ejection of cares. The MDS red limited assistance of staff nit. The corresponding Care CAA) dated 6/12/17, indicated dementia and needed staff vities of daily living. The CAA usually had a steady gait but aff assistance due to ed 7/1/16, indicated R37 was ependently with supervision ited assist. The careplan also able to reposition herself in careplan did not include the 4) side rail. with nursing assistant (NA)-B p.m., NA-B verified R37 tance to walk. NA-B stated but self transferred and side rail to get out of bed. ed policy regarding re Plans indicated, "An orehensive care plan that le objectives and timetables to medical, nursing, mental and s is developed for each v the professional services that each element of care; i. cognized standards of practice and conditions 8. sidents are ongoing and care s information about the sident's condition change" RVICES BY QUALIFIED	F 2				9/20/17
				02			5/20/17

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	-	AND HUMAN SERVICES & MEDICAID SERVICES	FORM APPROVED OMB NO. 0938-0391					
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE			
		245395	B. WING		08/1	7/2017		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
CROSSR	OADS CARE CENTE	R		965 MCMILLAN STREET WORTHINGTON, MN 56187				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 282	Continued From pa (b)(3) Comprehensi The services provid	ive Care Plans	F 28	2				
		ces provided or arranged by the facility, d by the comprehensive care plan,						
	care. This REQUIREMEN by:	ch resident's written plan of		Residents R14, 21, 24, and 30 hav	ve been			
	Based on interview and document review, the facility failed to follow the care plan for medication side effect and/or Tardive Dyskinesia (TD) monitoring for 4 of 5 residents (R24, R21, R14, R30) and antidepressant monitoring for 1 out of 5 residents (R21) reviewed for unnecessary medications.			evaluated by a physician for side-ef associated with Tardive Dyskinesia. has also been evaluated by a physi for side effects associated with thei antidepressant medication. These residents have been included in the program below for on-going side eff	. R21 cian r			
	Findings include:			monitoring.	COL			
	of psychotropic med Interventions includ	ed 7/5/17, indicated R24's use dications as a focus. ed monitoring for adverse ropic medications including		Any other resident potentially affect this deficient practice has been eva by a physician for possible side effect their medications (medications for T Antidepressants).	luated ect of			
	medical diagnosis in depression. R24's of (MDS) assessment Brief Interview for M	o facility on 6/14/17. R24's ncluded dementia and quarterly Minimum Data Set dated 6/21/17, identified a Mental Status (BIMS) score of y impaired cognition.		Nursing staff will be in-serviced on t importance of evaluating residents medications for TD or antidepressa side effects in accordance with the program and policy below.	taking ints for			
	order for Risperidol 0.25 milligrams (mg unspecified psychol	cation summary indicated an (antipsychotic medication) g) by mouth at bedtime for sis; initiated on 6/14/17. edication administration record		The facility has updated their medic administration policy to include asse residents routinely who take TD or antidepressant medication for side effects. Accordingly, the facility will the potential side effects to be mon	essing add			

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		AND HUMAN SERVICES	1				APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245395	B. WING_			08/	17/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CROSSR	OADS CARE CENTE	R			65 MCMILLAN STREET VORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	Continued From pa	age 8	F 28	82			
	<ul> <li>(MAR) from July 2017 to August 2017, indicated R24 was taking Risperidol daily.</li> <li>A review of R24's chart did not reveal a DISCUS (Dyskinesia Identification System: Condensed User Scale) had been completed to monitor the side effects of the Risperidol since admission.</li> </ul>				to the MAR, next to the medication the nurse can easily review for pot- side effects of those medications of med pass.	ential	
					The DON or her designee will audi weekly x4 and then monthly therea ensure that nurses are using this s	ifter to	
	R21's care plan dated 5/21/17, indicated R21's use of antidepressant medications as a focus. Interventions included monitor/document for side effects and effectiveness.				effect monitoring program. The au include a review of (10) residents receiving either TD or antidepressa medications.	ıdit will	
	medical diagnosis R21's quarterly MD	to facility on 5/28/15. R21's included major depression. OS assessment dated 8/1/17, score of 8 indicating moderately			The DON will report monthly to the Committee on this program.	QA	
	R21's current medication summary, indicated an order for Haloperidol (antipsychotic medication) 0.25 milligrams(mg) by mouth daily for depression/mood; initiated on 6/21/16. Review of R21's medication administration record (MAR) from July 2017 to August 2017, indicated R21 was taking Risperidol as ordered. R21's current medication summary also indicated an order for Sertaline (antidepressant medication) 150 mg by mouth daily for depression/mood; initiated on 11/10/16, which was an increase from previous order of Sertaline 100 mg by mouth daily for depression/mood. Review of R21's medication administration record (MAR) from July 2017 to August 2017, indicated R21 was taking Risperidol and Sertaline as ordered.						
	completed to monit	t reveal a DISCUS had been tor the side effects of the s chart did not reveal side effect					

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		AND HUMAN SERVICES				FORM	10/23/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATI	E SURVEY PLETED
		245395	B. WING			08/	17/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CROSSF	OADS CARE CENTE	R			65 MCMILLAN STREET VORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	monitoring docume medication increase During interview on director of nursing ( orders for side effect documentation in R 8/17/17, at 8:08 a.m DISCUS assessme admission, starting medication, when the or every 6 months. the DON verified no been completed sim facility. The DON we documentation that completed on R21. R14 was admitted of Order Report dated administer Celexa depression/mood; i Risperidone 2 mg, related to other sch The Care Area Asse identified R14 with depression and psy psychotropic medic primary care provid at risk for Tardive D The care plan dated used psychotropic ne behaviors of "depre psychosis". Staff we antipsychotic medic and to monitor side medication every sl	nted for Sertaline following e. 8/16/17, at 2:31 p.m. the (DON) stated she did not see ct monitoring or 21's chart. The next day on h. the DON stated a baseline ent should be done upon a new antipsychotic here was a significant change Later that day at 11:10 a.m., o DISCUS assessment had here R24 had been admitted to as not able to find any a DISCUS had been on 4/10/08, and the Physician 18/17/17, directed staff to 10 mg by mouth (PO) daily for nitiation on 8/1/17, and PO at bed time for delusional izophrenia. essment (CAA) dated 2/5/17, diagnoses of "schizophrenia, vchosis" which required hations prescribed by the er. It also indicated R14 was	F 2	282			

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		AND HUMAN SERVICES				FORM /	10/23/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G		(X3) DATE	E SURVEY PLETED
		245395	B. WING			08/1	17/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE		
CROSSF	ROADS CARE CENTE	R		965 MCMILLAN STREET WORTHINGTON, MN 561	87		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICII	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 282	disorder and staff w medication as orde document the side medication; howeve documentation Risp adequately monitor On 8/16/17, at 8:20 stated they do not h system; stating, "w monitoring and beh possible". R30 was admitted of MDS dated 5/19/17 non-Alzheimer's de identified that R30 v antipsychotic medic The MDS dated 5/1 rarely/never unders term memory probl impaired in decision also indicated R30 rejection of cares. The CAA dated 11/2 antidepressants an for depression, deli and her behaviors/n R30 was at risk for effects. The physician orde on antidepressants mg and antipsychot	vere directed to administer red and to monitor and effect and effectiveness of the er, the facility lack peridone and Celexa were	F 28				

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		AND HUMAN SERVICES				FORM	10/23/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
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NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CROSSF	ROADS CARE CENTE	R			65 MCMILLAN STREET VORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	for side effects and monitor and docum reactions of PSYC tardive dyskinesia a plan also indicated, ordered. Monitor/do effectiveness." and monthly. On 8/16/17, at 1:48 assisted with staff, recliner in the dining playing. No behavio At 2:13 p.m. medica DISCUS completed score of zero. At 2:16 a.m. registed did not have many anxious once in a w On 8/17/17, at 8:32 DISCUS for TD mo at baseline before a started, with signific least annually, and them here every six At 9:20 a.m. on 8/1 (ADON) stated she residents on admise every six months. On 8/17/17, at 1:27 expected staff to fo An undated policy p	effectiveness Q-SHIFT and nent PRN any adverse HOTROPIC medications for and other reactions. R30's care , "Administer medications as bocument for side effects and for Pharmacy to review B p.m. R30 was observed walker, and transfer belt to a g room where music was bors were exhibited. al records verified the last d for R30 was 10/19/16, with a ered nurse (RN)-C stated R30 behaviors but might get while. C a.m. the DON stated a onitoring should be completed antipsychotic medication cant dosage changes, and at stated, "But we complete	F 2	282			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/23/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CROSSR	OADS CARE CENTE	R			65 MCMILLAN STREET VORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282 F 323 SS=E	Nursing staff shall r the following side e consequences of an Attending Physician Undated policy prov Comprehensive in comprehensive car measurable objectiv resident's medical, psychological needs resident f. Identify are responsible for Reflect currently red for problem areas a 483.25(d)(1)(2)(n)(7 HAZARDS/SUPER (d) Accidents. The facility must en (1) The resident env from accident hazar (2) Each resident rea and assistance dev (n) - Bed Rails. The appropriate alternat bed rail. If a bed or must ensure correct maintenance of bed to the following eler (1) Assess the reside from bed rails prior	nonitor for and report any of ffects and adverse ntipsychotic medications to the nonitor for and verse ntipsychotic medications to the nonitor dyskinesia" wided by the facility Care Plans ndicated, "An individualized e plan that includes ves and timetables to meet the nursing, mental and s is developed for each with e professional services that each element of care; i. cognized standards of practice and conditions" 1)-(3) FREE OF ACCIDENT VISION/DEVICES sure that - vironment remains as free rds as is possible; and eceives adequate supervision ices to prevent accidents. e facility must attempt to use tives prior to installing a side or side rail is used, the facility it installation, use, and d rails, including but not limited ments.	F 2	282			9/20/17

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		& MEDICAID SERVICES	(X2) MULT	TIPLE CONSTRUCTION		<u>. 0938-039</u> E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,	NG	· · ·	IPLETED
		245395	B. WING _		08/	17/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
CROSSR	OADS CARE CENTE	R		965 MCMILLAN STREET WORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 323	Continued From pa	age 13	F 32	23		
		dent representative and obtain				
	appropriate for the This REQUIREME	bed's dimensions are resident's size and weight. NT  is not met as evidenced				
	by: Based on observation, interview and document review, the facility failed to ensure assistive devices were assessed to ensure safe use for 2 of 3 residents reviewed for accidents (R37, R18) and 4 other residents whose environments were			Residents R37, R18 have rails adjusted to meet the o standards. Also, R9, 27, 3 their bed rails adjusted so	officials 8, 42 have had they are safe	
		(R9, R27, R38, R42) for	were and meet industry		roughout the	
	Findings include:	on 8/16/17, at 11:34 a.m.		if any problems are found rails are not ill-fitting or not corrections have been made	safe,	
		/4 side rails bilaterally on the		Nursing staff will be in-serv		
	On 8/16/17, at 3:19 observed in the up	p.m. R37's side rail was position. The director of ted at the rail with the		proper standards for side r devices and on the program below.	ails as assistive	
	surveyor. It was no side of the bed had	bied the quarter rail on the door significant movement from The DON stated, "this is		The policy for side rail use updated. A new program or removal has been institute	of side rail	
	would ask maintenative the side rail. Furthe	g to safety, and stated she ance to see if he could tighten er, the DON stated side rail completed upon admission,		rails will be removed where other safety measures inst side rails exist, a program safety has been instituted	ituted. Where of ensuring	
	quarterly, and with changes. The DON	medication and mobility I also stated the side rail y checked for safety with each		of checking the side rails r ensure that they meet the required in the industry. T occurs monthly and is doc any corrections made to si	outinely to standards his review umented so that	
	6/12/17, indicated F	num Data Set (MDS) dated R37 was rarely understood, term memory problems, and		tracked. An audit will be done by fa		

Facility ID: 00407

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	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTR	RUCTION		<u>. 0938-039</u> E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG			IPLETED
		245395	B. WING _	WING			17/2017
NAME OF	PROVIDER OR SUPPLIER				DRESS, CITY, STATE, ZIP CO	DDE	
CROSSF	ROADS CARE CENTE	R			LAN STREET IGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(E.	PROVIDER'S PLAN OF COR ACH CORRECTIVE ACTION SS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 323	had moderately im MDS also indicated disorganized thinki behaviors and no r indicated R37 requ for locomotion on u Area Assessment of R37 had advanced assistance with act also indicated R37 at times needed st unsteadiness. R37's careplan dat able to transfer ind and stand by or lim indicated R37 was bed. However, the use of a quarter (1 During an interview on 8/16/17 at 1:53 required staff assis R37 had dementia utilized the quarter On 8/16/17, at 2:22 needed stand by a steady on her feet. her side rails to pu further stated if a r more than a little s to fix. On 8/16/17, at 2:26 stated nurses did r assessments but t the assistant DON	paired decision making. This d R37 had inattention and ing, but experienced no rejection of cares. The MDS uired limited assistance of staff unit. The corresponding Care (CAA) dated 6/12/17, indicated d dementia and needed staff tivities of daily living. The CAA usually had a steady gait but aff assistance due to ted 7/1/16, indicated R37 was lependently with supervision nited assist. The careplan also able to reposition herself in careplan did not include the	F 32	mainte month rails se (ED) a will be kept sa industr Mainte	enance or their design based on (10) resider elected by the facility A t random. The basis of to ensure that side ra afe and within the star y. enance will report mon ittee on this program.	nts with side Administrator of the audit ils are being ndards in the thly to the QA	

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		AND HUMAN SERVICES				FORM	10/23/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245395	B. WING	i		08/	17/2017
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CROSSF	ROADS CARE CENTE	R			965 MCMILLAN STREET WORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	Coordinator stated rail assessments sk whether they wante complete the side r MDS Coordinator fu physically checked completed an asses were safe, and that the rail and the bed when a side rail wa maintenance to tigh MDS Coordinator v rail assessment wa On 8/16/17, at 2:51 expectation was that physically checked were safe. The DOI standard practice p On 8/17/17, at 8:22 much movement in balance problems f hold on to it when g On 8/17/17, at 9:07 completed side rail quarterly, at the tim when there were m ADON stated she d side rails for safety on the form. On 8/17/17, at 10:0 herself in and out o R18's admission M R18's cognition was R18 needed staff as	when she completed the side he would ask the resident ed the rail, and that she would ail assessments quarterly. The urther explained that she the side rails when she ssment to make sure they there were no gaps between 1. The MDS Coordinator stated s loose she would call hen or replace the rail. The rerified R37's most recent side is dated 6/23/16. p.m. the DON stated her at side rails would be when assessed to ensure they N also stated would follow protocol. c a.m. the DON stated too a side rail could cause for a resident attempting to getting up. c a.m. the ADON stated she assessments upon admission, the of a significant change, and obility changes. However, the did not physically check the because it was not identified 22 a.m. RN-B stated R37 gets	F	323			

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		AND HUMAN SERVICES				FORM	10/23/2017 APPROVED 0938-0391
STATEMENT OF DEFINAND PLAN OF CORRE	CIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245395	B. WING			08/ <sup>,</sup>	17/2017
NAME OF PROVIDER	R OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CROSSROADS	CARE CENTE	R			65 MCMILLAN STREET VORTHINGTON, MN 56187		
	ACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
had a fractur with tra- also in seriou R18's used of transfe walker During p.m. R proper bed ou observore one th On 8/1 laying On 8/1 DON v rail. Th She st mover was ex was no Other followi attach R42's in the was ol	re and needed ansfers, toilet ndicated R18 y is injury. care plan dat grab bars to m g and repositiver with superv rs. g an initial obs R18's 1/4 side rly. The rail w utward about to vation, R18 st ing I want the 16/17, at 7:04 in bed with 1/ 17/17, at 8:21 went to R18's he DON verifi- tated, "What of ment back and xcessive moti- ot stable. observations ing side rails to red to the bed 1/4 side rail of up position of	<ul> <li>cit related to compression d limited to extensive assist ting and ambulation. It was was at risk for falls with</li> <li>ted 7/28/17, indicated R18 naximize independence with oning in bed, and was able to vision using four wheeled</li> <li>servation on 8/14/17, at 7:21 rail was noted not to fit vas noted to move from the two inches. At the time of the tated to the surveyor, "That is em to fix."</li> <li>a.m. R18 was observed to be /4 side rail up on the door side.</li> <li>a.m. the surveyor and the room to look at the 1/4 side ed the 1/4 side rail was loose.</li> <li>concerns me most is the d forth". The DON stated there ion of the side rail and that it</li> </ul>	F3	323			

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 10/23/2017 APPROVED . 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245395	B. WING		08/	17/2017	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP			
CROSSE	OADS CARE CENTE	R		965 MCMILLAN STREET WORTHINGTON, MN 56187			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 323 F 329 SS=E	R38's 1/4 side rail of in the up position of was observed to me about 3-4 inches. R27's 1/4 side rail of in the up position of was observed to me about 3-4 inches. R9's 1/4 side rail or observed in up posi The rail was observ outward about 3-4 i 483.45(d)(e)(1)-(2) FROM UNNECESS 483.45(d) Unneces Each resident's dru unnecessary drugs drug when used (1) In excessive dos therapy); or (2) For excessive do (3) Without adequa (4) Without adequa (5) In the presence which indicate the of discontinued; or (6) Any combination	on the door side was observed n 8/15/17, at 9:56 a.m. The rail ove from the mattress outward on the door side was observed n 8/15/17, at 9:59 a.m. The rail ove from the mattress outward n the door side of the bed was ition on 8/15/17, at 3:57 p.m. red to move from the mattress nches. DRUG REGIMEN IS FREE SARY DRUGS sary Drugs-General. g regimen must be free from . An unnecessary drug is any se (including duplicate drug uration; or	F 323			9/20/17	

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	-	AND HUMAN SERVICES & MEDICAID SERVICES	FORM APPR OMB NO. 0938				
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE		
		245395	B. WING _		08/1	7/2017	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
CROSSR	OADS CARE CENTE	R		965 MCMILLAN STREET WORTHINGTON, MN 56187			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 329	Continued From pa	ge 18	F 32	9			
	483.45(e) Psychotro Based on a compre resident, the facility	hensive assessment of a					
	drugs are not given medication is neces	nave not used psychotropic these drugs unless the ssary to treat a specific sed and documented in the					
	gradual dose reduct interventions, unless an effort to disconti This REQUIREMEN by: Based on observat review, the facility far medications were n and/or adverse effer with the consulting	NT is not met as evidenced ion, interview and document ailed to ensure psychoactive nonitored for side effects icts, and/or failed to follow-up pharmacist (CP) or 4 of 5 residents (R24, R21,		R 14, 21, 24, 30 had their psychoa medications reviewed including sid effects and effectiveness by a phys Any other resident for whom psych medications are prescribed has be reviewed for effectiveness and side effects and changes made where	e sician. oactive en		
	Findings include: R24 was admitted of diagnoses (dx) include depression. R24's of (MDS) assessment Brief Interview for M 4, indicating the res cognition. R24's current media	on 6/14/17, and had medical uding dementia and quarterly Minimum Data Set dated 6/21/17, identified a Mental Status (BIMS) score of ident had severely impaired cation summary indicated a Risperidol (antipsychotic		necessary. Consulting pharmacist recommendations have been revie going back (30) days to ensure the been properly processed and any r have been managed as required. Nurses will be trained on the impor of monitoring side effects and effectiveness of psychoactive medi for their residents as indicated by th program described below. Additior nursing management and nursing s be in-serviced by the DON on the	wed y have nissed tance cations ne nally,		

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PRINTED: 10/23/2017

							0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				E SURVEY PLETED
		245395	B. WING _			08/1	7/2017
NAME OF I	PROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE	Ξ	
CROSSF	OADS CARE CENTE	R			55 MCMILLAN STREET ORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 329	Continued From pa	age 19	F 32	9			
	medication) 0.25 m	illigrams (mg) by mouth at sified psychosis; initiated on			importance of following through wit consultant pharmacist recommend		
	administration record (MAR) from July 2017 through August 2017, indicated R24 was taking Risperidol daily.				The facility policy for psychoactive medications has been updated to in monitoring for side effects routinely each administration) and for		
	R24's chart did not reveal a DISCUS had been completed to monitor the side effects of the Risperidol since admission. DISCUS-an assessment used to identify side effects associated with the use of antipsychotic				effectiveness. Side effect monitorin effectiveness of psychoactive medi will be added to the resident MARs residents who are prescribed	cations	
		nesia Identification System:			psychoactive medications. As for consultant pharmacist recommendations, a copy will be m	ade of	
	medical diagnosis i R21's quarterly MD	to facility on 5/28/15. R21's included major depression. IS assessment dated 8/1/17, core of 8 indicating moderately			each pharmacist recommendation checked off by the DON or her des once completed (completion means processed through to the physician DON and completed and "check-of means a check mark and initial pla	and ignee s or f"	
	order for Haloperid 0.25 mg orally dail initiated on 6/21/16 July 2017 through A	cation summary indicated an ol (antipsychotic medication) y for depression/mood; . Review of R21's MAR from August 2017, indicated ninistered daily as ordered.			the upper right hand corner of each recommendation when completed) them the copy will be compared ag the original. At the end of each mo the DON or designee reviews all	and ainst nth,	
	The current medica an order for Sertali 150 mg by mouth of initiated on 11/10/1 previous order of S for depression/moo	ation summary also identified ne (antidepressant medication) laily for depression/mood; 6, which was an increase from certaline 100 mg by mouth daily od. Review of R21's MAR			pharmacy consultant recommendation ensure they are completed. If any a completed, the DON addresses the ensures completion. These completion copies of pharmacy recommendation into a monthly file and are kept for months.	are not em and eted ons go	
	R21's chart lacked monitor the side eff	august 2017 indicated both given as ordered. a DISCUS assessment, to fects of the Haloperidol. R21's I side effect monitoring			The DON will monitor weekly x4 an monthly thereafter (10) residents ea time who are on psychoactive medications to ensure that nurses a properly monitoring side effects and	ach are	

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	OF DEFICIENCIES	<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPL	E CONSTRUCTION	MB NO. (X3) DATE	SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:		BUILDING			PLETED	
		245395	B. WING _	VING			7/2017	
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 965 MCMILLAN STREET					
CROSSF	OADS CARE CENTE	R						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 329	documented for Sertaline following medication			29	effectiveness of their psychoactive			
	increase. A pharmacy note fr	om consulting pharmacist			medications. The DON will report monthly to the QA Committee on this program.			
	(CP)-B dated 12/2/ assessment was n Subsequent pharm CP-B did not addre assessment. Pharm	16, indicated a DISCUS ot available in the chart. hacy notes from CP-A and less lack of DISCUS nacy notes from 12/2/16, did f side effect monitoring for			The pharmacy consultant recommendations are audited by th facility ED or his designee: the fac will look for the check-mark and ini the DON or her designee in the upp right hand corner of each copy of the monthly pharmacy consultant recommendation to ensure it has be	ility ED tial of per ne		
	director of nursing identify side effect	n 8/16/17, at 2:31 p.m. the (DON) stated she did not monitoring for the identified as documentation evident in			properly processed. If no check m initial exists, the ED will bring it to t attention of the DON for processing	ar or he		
	baseline DISCUS a upon admission, up prescribed antipsy change and/or eve 11:10 a.m., the DO assessment had be admission and was	onfirm a DISCUS had been						
	Medication Use inc monitor for side eff dyskinesia (TD) . R14 was admitted Order Report dated administer Celexa depression/mood;	ated facility policy Antipsychotic licated the nursing staff would ects including tardive on 4/10/08, and the Physician d 8/17/17, directed staff to 10 mg by mouth (PO) daily for initiation on 8/1/17, and PO at bed time for delusional hizophrenia.						

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		AND HUMAN SERVICES				FORM	10/23/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245395	B. WING			08/	17/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
CROSSR	OADS CARE CENTE	R			65 MCMILLAN STREET VORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Continued From pa	ge 21	F3	329			
	identified R14 with depression and psy psychotropic medic primary care provid at risk for Tardive D The Review of cons medication regimer "takes citalopram 1 record, the medicat federal law to evalue reduction. The CP a to no depression ar treatment". Howeve through the CP's re Pharmacy consulta resident was on Be time. "please asses of this medication for [discontinue] is app did not follow throug Care plan dated 5/5 used psychotropic for behaviors of "depro- psychosis". Staff we antipsychotic medic and to monitor side medication every sl 4/28/17, also indicat disorder and staff we medication as orde	sultant pharmacist's in dated 4/3/17, stated R14 0 mg daily." According to this tion was due per state and late the potential dose also stated R14 has "minimal nd may no longer require er, the facility did not follow ecommendation. Int note dated 3/7/17, revealed inztropine for a long period of as if you are still desired benefit or [R14] OR if a DC propriate". However, the facility gh the CP's recommendation. 5/17, indicated R14 had been medication to manage ession, schizophrenia, ere directed to administer cation as ordered by physician e effect and effectiveness of hift. The care plan dated ated R14 had major depressive were directed to administer red and to monitor and					
	medication; howeve	peridone and Celexa were					

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	RINTED: 10/23/2017 FORM APPROVED MB NO. 0938-0391										
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
		245395	B. WING			08/ <sup>.</sup>	17/2017				
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE						
CROSSROADS CARE CENTER				965 MCMILLAN STREET WORTHINGTON, MN 56187							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE				
F 329	O Continued From page 22		F३	329							
	stated they do not h system; stating, "we	a.m. registered nurse (RN)-D have a side effect monitoring e will put the side effect havior monitoring as soon as									
	<ul> <li>monitoring and behavior monitoring as soon as possible".</li> <li>When interviewed on 8/16/17, at 9:42 a.m. the DON indicated the facility had a system to ensure the pharmacist recommendation followed through; however, it was missed and the resident care coordinator should have given the recommendation to the physician for review/response. "The same issue for March and April [recommendation] were not addressed."</li> <li>Furthermore, the DON admitted they did not have system in place to monitor side effect for psychoactive medication and stated, "I do accept that."</li> <li>R30 was admitted on 11/23/14. R30's quarterly MDS dated 5/19/17, included diagnoses of non-Alzheimer's dementia and depression, and identified that R30 was prescribed both an antipsychotic medication and an antidepressant. The MDS dated 5/19/17, indicated R30 was rarely/never understood, had a short and long term memory problem and was moderately impaired in decision making. The quarterly MDS also indicated R30 had no behaviors and no rejection of cares.</li> <li>The CAA dated 11/23/16, indicated R30 was on antidepressants and an antipsychotic medication for depression, delirium and to help with anxiety and her behaviors/mood. The CAA also indicated R30 was at risk for psychotropic drug side effects.</li> <li>The physician orders 8/1/17, indicated R30 was</li> </ul>										

Facility ID: 00407

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	FORM	10/23/2017 APPROVED 0938-0391							
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245395	B. WING			08/	17/2017		
NAME OF F	PROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-			
CROSSROADS CARE CENTER			965 MCMILLAN STREET WORTHINGTON, MN 56187						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE		
F 329	Continued From pa	age 23	F 3	329					
	on antidepressants Remeron 7.5 mg, Zoloft 25 mg and antipsychotic Risperdal 0.25 mg.								
	Review of R30's August 2017 MAR indicated R30 was taking Risperdal, Remeron and Zoloft daily.								
	for side effects and monitor and docum reactions of PSYC tardive dyskinesia a plan also indicated, ordered. Monitor/do	ed 12/13/16, indicated: Monitor I effectiveness Q-SHIFT and nent PRN any adverse HOTROPIC medications for and other reactions. R30's care , "Administer medications as ocument for side effects and I for Pharmacy to review							
	assisted with staff,	3 p.m. R30 was observed walker, and transfer belt to a g room where music was ors were exhibited.							
		al records verified last d for R30 was 10/19/16, with a							
		ered nurse (RN)-C stated R30 behaviors but might get while.							
	DISCUS for TD mo at baseline before a started, with signific	2 a.m. the DON stated a pnitoring should be completed antipsychotic medication cant dosage changes, and at stated, "But we complete x months."							
	(ADON) stated she	7/17, the assistant DON completed DISCUS for sion for a baseline and then							

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/23/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245395	B. WING			08/	17/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CROSSR	OADS CARE CENTE	र			65 MCMILLAN STREET VORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Continued From pa every six months.	ge 24	F 3	29			
	just filled in for the r monthly medication recommendation fo for R30. CP-A state given any recomme	9 a.m. CP-A stated he had egular CP-B on 8/1/17, for the review and had not made a r a DISCUS to be completed d he did not believe he had endation for any resident at the nonitoring completed.					
		p.m. DON stated she low residents' care plans.					
	Antipsychotic Medic Nursing staff shall n the following side et consequences of an	provided by the facility cation Use indicated, " 14. nonitor for and report any of ffects and adverse ntipsychotic medications to the i: tardive dyskinesia"					
F 428 SS=E	medications will be guidelines listed C documented for dos guidelines for more	licated, "All psychotropic used within the dosage Or clinical justification will be sages that exceed the listed than 48 hours." DRUG REGIMEN REVIEW,	F 4	28			9/20/17
	c) Drug Regimen R	eview					
		en of each resident must be nce a month by a licensed					
	brain activities asso	lrug is any drug that affects iciated with mental processes se drugs include, but are not					

Facility ID: 00407

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245395	B. WING_			08/ <sup>,</sup>	17/2017
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CROSSF	ROADS CARE CENTE	R			65 MCMILLAN STREET VORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	limited to, drugs in t (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist to the attending phy facility's medical dir and these reports n (i) Irregularities includring that meets the (d) of this section for (ii) Any irregularities during this review m separate, written re attending physician director and directo minimum, the resid and the irregularity (iii) The attending p resident's medical m irregularity has been action has been tak be no change in the physician should do the resident's medical (5) The facility must and procedures for review that include, frames for the differ steps the pharmacia	the following categories: the following categories: must report any irregularities ysician and the rector and director of nursing, nust be acted upon. ude, but are not limited to, any e criteria set forth in paragraph or an unnecessary drug. s noted by the pharmacist nust be documented on a port that is sent to the and the facility's medical or of nursing and lists, at a lent's name, the relevant drug, the pharmacist identified. whysician must document in the record that the identified n reviewed and what, if any, ken to address it. If there is to a medication, the attending boument his or her rationale in	F 4	-28			

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STATEMENT	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA		JLTIPLE CONSTRUCTION (X3) DATE SURVEY
IND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	DING COMPLETED
		245395	B. WING	G 08/17/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSF	ROADS CARE CENTE	R		965 MCMILLAN STREET WORTHINGTON, MN 56187
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIO
F 428	Continued From pa	ae 26	F4	428
	to protect the reside	-		
	Based on observative interview, the facility for ecommendations of through with for 4 of R21, R14 and R30) medications. Findings include: R24 was admitted of diagnoses (dx) include diagnoses (dx) include diagnoses (dx) include pression. R24's of (MDS) assessment Brief Interview for N4, indicating the rest cognition. R24's current medi physician order for medication) 0.25 m bedtime for unspect 6/14/17. Review of administration records through August 201 Risperidol daily. R24's chart did not	tion, interview and document ailed to ensure pharmacy were identified, and or followed of 5 residents reviewed (R24, ) who utilized psycho active on 6/14/17, and had medical uding dementia and quarterly Minimum Data Set t dated 6/21/17, identified a Mental Status (BIMS) score of sident had severely impaired cation summary indicated a Risperidol (antipsychotic illigrams (mg) by mouth at cified psychosis; initiated on R24's medication rd (MAR) from July 2017 17, indicated R24 was taking reveal a DISCUS had been for the side effects of the		Residents R24, R21, R14, and R30 evaluated to ensure DISCUS assessments are current and medication side effect monitoring established. Psychotropic med review form implemented that identifies psychotropic med in use, current dose, last dose reduction, as well as targeted mood/behavior, and summarization of resident response in relation to intended outcomes as well as any adverse effects noted, providing MD an objective means of evaluating for dose reduction and side effects, supporting documentation/rationale for decision re-continued use and/or dose adjustment. The facility policy has been reviewed and updated to ensure pharmacy consultation reports, upon receipt, are directed to the DON or designated nurse for review, followed by review per physician on next scheduled in-house visit unless resident condition indicates review should be sooner, at which time the pharmacy recommendation is faxed to the primary MD.
	assessment used t associated with the medications (Dyski Condensed User S	mission. DISCUS-an o identify side effects use of antipsychotic nesia Identification System: cale (DISCUS). There was no icist (CP)recommendation sight.		Upon review of pharmacy recommendation by MD., the form is uploaded into electronic medical record, making information accessible for next monthly review per consulting pharmacist. Consulting pharmacist will report to DON or designated nurse, a list of any

Facility ID: 00407

If continuation sheet Page 27 of 33

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES           (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	0938-039
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMI	PLETED
		245395	B. WING			08/1	17/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CROSSR	OADS CARE CENTE	R			65 MCMILLAN STREET /ORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 428	Continued From pa	age 27	F 4	28			
	medical diagnosis R21's quarterly MD identified a BIMS s impaired cognition. R21's current medio order for Haloperid 0.25 mg orally dail initiated on 6/21/16 July 2017 through A Risperidol was adm The current medica an order for Sertalii 150 mg by mouth of initiated on 11/10/1 previous order of S for depression/moo	ication summary indicated an lol (antipsychotic medication) ly for depression/mood; 5. Review of R21's MAR from August 2017, indicated ninistered daily as ordered. ation summary also identified ne (antidepressant medication) daily for depression/mood; 6, which was an increase from Sertaline 100 mg by mouth daily od. Review of R21's MAR August 2017 indicated both			unreturned pharmacy recommend at time of monthly review before ex- the building. DON or nurse design follow-up on non-response. DON or designee will audit complia with plan of correction monthly foll review in Quarterly QA meeting. Compliance/effectiveness of plan or reviewed per Quality Assurance Te next scheduled meeting.	xiting nee will ance owed by will be	
R21 mor chai doct incre A ph india avai note of D 12/2	monitor the side ef chart did not revea	a DISCUS assessment, to fects of the Haloperidol. R21's I side effect monitoring ertaline following medication					
	indicated a DISCU available in the cha notes from CP-A a of DISCUS assess	rom CP-B dated 12/2/16, S assessment was not art. Subsequent pharmacy nd CP-B did not address lack ment. Pharmacy notes from dress lack of side effect aline.					
	director of nursing identify side effect	n 8/16/17, at 2:31 p.m. the (DON) stated she did not monitoring for the identified as documentation evident in					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mul A. Build		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245395	B. WING	i		08/	17/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
CROSSR		P			965 MCMILLAN STREET		
CRUSSR	UADS CARE CENTER	n in the second s			WORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 428	Continued From pa R21's chart. On 8/17/17, at 8:08 baseline DISCUS a upon admission, up prescribed antipsyc change and/or ever 11:10 a.m., the DOI assessment had be admission and was documentation to co completed for R21. During interview on stated he generally DISCUS be conduc Diskynesia). CP-A CP-B during August conducted the phar CP-A stated he wou no call was returned R14 was admitted the Physician Order Re staff to administer C daily for depression 8/1/17, and Risperid delusional related to R14's Care Area Ass identified diagnoses depression and psy psychotropic medic primary care provid at risk for Tardive D	ge 28 a.m. the DON stated a ssessment should be done on initiation of a newly chotic medication, a significant y 6 months. Later that day at N verified no DISCUS een completed since R24 since unable to locate onfirm a DISCUS had been 8/17/17, at 10:38 a.m. CP-A recommended quarterly sted to watch for TD (Tardive stated he had only filled in for t, but that CP-B usually macy reviews for this facility. Id have CP-B call back, but d. o facility on 4/10/08. R14's sport dated 8/17/17, directed Celexa 10 mg by mouth (PO) /mood with a start date of done 2 mg, PO at bed time for o other schizophrenia ssessment (CAA) 2/5/17, s of "schizophrenia, rchosis" which required ations prescribed by the er. It also indicated R14 was syskinesia.	F 4		DEFICIENCY)	RATE	DATE
	medication regimer	0 dated 4/3/17, stated R14 0 mg daily." According to this					

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		AND HUMAN SERVICES				FORM	10/23/2017 APPROVED
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATI	0938-0391 E SURVEY IPLETED
		245395	B. WING			08/	17/2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
CROSSF	ROADS CARE CENTE	R		-	65 MCMILLAN STREET VORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 428	record, the medical federal law to evalu reduction. The CP a to no depression ar treatment". Howeve through whether the the recommendation the facility. A pharmacy consult Attending Physician revealed the reside long period of time if you still desire be [R14] OR if a DC [d However, the there determine whether the recommendation facility. On 8/16/17, at 9:42 facility had a system pharmacist's recom through. However, the been missed for R1 coordinator should recommendation to DON added, "The se March and April [rea addressed." Further they did not have sy effect for psychoac On 8/17/17, at 10:5 Avera Long- Term p had given recommen medications. Howe The surveyor gave	tion was due per state and late the potential dose also stated R14 has "minimal nd may no longer require er, the CP did not follow e physician had acted upon ons pharmacist was made to tant note titled "Note to n/Prescriber" dated 3/7/17, nt was on Benztropine for a and indicated: "please assess nefit of this medication for liscontinue] is appropriate". was no follow through to the physician had acted upon on the pharmacist made to the enter the DON indicated the min place to assure the mendations were followed she acknowledged this had 14 and stated the resident care have given the o the physician for review. The same issue occurred when the commendations] were not ermore, the DON admitted ystem in place to monitor side	F 4	428			

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE					FORM	10/23/2017 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	245395	B. WING			08/	17/2017
NAME OF PROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CROSSROADS CARE CENTE	R			65 MCMILLAN STREET VORTHINGTON, MN 56187		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
followed through. N CP-B. R30 was admitted R30's quarterly MD Dx of Non-Alzheim and indicated R30 medication and an dated 5/19/17, india understood, had a problem and was n making. The quarte had no behaviors w R30's CAA dated 1 antidepressants an for depression, deli anxiety and her bel indicated R30 was side effects. R30's physician ord on antidepressants mg, and antipsycho Review of R30's Au was taking Risperd R30's careplan dat for side effects and monitor and docum reactions of PSYCI tardive dyskinesia a careplan also indic as ordered. Monito	age 30 e recommendations were not lo email was received from to the facility on 11/23/14. S dated 5/19/17, included a er's Dementia and Depression, was taking an antipsychotic antidepressant. The MDS cated R30 was rarely/never short and long term memory noderately impaired in decision erly MDS also indicated R30 with no rejection of cares. 1/23/16, indicated R30 was on in an antipsychotic medication irium Dx and to help with haviors/mood. The CAA also at risk for psychotropic drug ders 8/1/17, indicated R30 was a Remeron 7.5 mg, Zoloft 25 bit Risperdal 0.25 mg. ugust 2017 MAR indicated R30 lal, Remeron, and Zoloft daily. ed 12/13/16, indicated Monitor affectiveness Q-SHIFT and nent PRN any adverse HOTROPIC medications for and other reactions. R30's ated, "Administer medications r/document for side effects and for Pharmacy to review	F 4	28			

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		AND HUMAN SERVICES				FORM	10/23/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245395	B. WING _			08/	17/2017
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
CROSSF	ROADS CARE CENTE	R			55 MCMILLAN STREET ORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 428	On 8/16/17, at 1:48 assisted with staff, recliner in the dining playing. At 2:13 p.m. medica DISCUS completed score of zero. At 2:16 a.m. register had not many beha once in a while. On 8/17/17, at 8:32 for TD monitoring s baseline before ant with significant dos annually, and stated every six months." At 9:20 a.m. assista completed DISCUS and every six month On 8/17/17, at 10:5 just filled in for the monthly medication recommendation for for R30. CP-A state given any recommendation for R30. CP-A's d	<ul> <li>a. p.m. R30 was observed walker and transfer belt to a g room where music was</li> <li>al records verified last d for R30 was 10/19/16, with a</li> <li>ared nurse (RN)-C stated R30 wors and might get anxious</li> <li>a.m. DON stated a DISCUS should be completed at tipsychotic medication started, age changes and at least d, "But we complete them here</li> <li>ant DON (ADON) stated she S on admission for baseline hs.</li> <li>a.m. CP-A stated he had regular CP-B on 8/1/17, for the n review and had not made a or a DISCUS to be completed ed he did not believe he had endation for any resident at the monitoring completed.</li> <li>f. p.m. DON stated she illow residents' careplans.</li> <li>kocumentation dated 8/1/17, mendation for side effects</li> </ul>	F 42	28			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245395	B. WING			08/ <sup>,</sup>	17/2017
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CROSSE	OADS CARE CENTE	R			965 MCMILLAN STREET		
		-			WORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	Continued From pa	ge 32	F4	28			
	Medication Use, inc monitor for side effe dyskinesia (TD) ." monitor for and rep effects and adverse antipsychotic medic Physician: tardive Review of the unda policy, indicated the supply a written rep to the attending phy assessment and me the resident." 2. The must supply a writte found to the attendi medical director and 5 working days of e acted upon 4. The within 35 days of re addressed by the a attempts) within the forwarded to the me In addition, a Policy 6/15, Consultant PF Requirements indic that the consultant but is not limited to: responsible prescriit	e dyskinesia" ted Consultant Pharmacist e consultant pharmacist must oort of any irregularities found visician including psychoactive onitoring to meet the needs of The consultant pharmacist en report of any irregularities ng physician, the facility's d the director of nursing within xits. These reports must be e reports shall be acted upon ceipt 6. Any irregularity not ttending physician (after 3 e 35 day time frame will be edical director for action" provided by the facility dated narmacist Services Provider ated, " F. Specific activities pharmacist performs includes, 2) Communicating to the ber and the facility leadership nendations for changes in					

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 3, 2017

Mr. Scott Kessler, Administrator Crossroads Care Center 965 McMillan Street Worthington, MN 56187

Re: State Nursing Home Licensing Orders - Project Number S5395027

Dear Mr. Kessler:

The above facility was surveyed on August 14, 2017 through August 17, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Crossroads Care Center September 3, 2017 Page 2

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Kathyrn Serie at (507) 476-4233 or email: kathryn.serie@state.mn.us**.

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

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

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

Sincerely, Mark Meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: <u>mark.meath@state.mn.us</u> Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

Minnesc	ta Department of He	alth				
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
	IN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:       COMPLETED         00407       B. WING       08/17/2017         F PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       08/17/2017         SROADS CARE CENTER       965 MCMILLAN STREET WORTHINGTON, MN 56187       VORTHINGTON, MN 56187         SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION       (X5)					
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CROSSE	OADS CARE CENTE	R				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
2 000	Initial Comments		NN NUMBER:     A. BUILDING:     COMPLETED       B. WING     08/17/2017   STREET ADDRESS, CITY, STATE, ZIP CODE       965 MCMILLAN STREET     DOR       WORTHINGTON, MN 56187     COSS-REFERENCED TO THE APPROPRIATE     COMPLETE       DRMATION)     PREFIX     CROSS-REFERENCED TO THE APPROPRIATE     COMPLETE       DATE     2 000     2 000     DEFICIENCY)     COMPLETE   ORDER tes section been issued pection, it is cies cited back violation accordance d by rule of h. h. thas been all the tag ated below. , failure to considered ance upon part rule will ven if the item spection was assessments e with these is tis made to ceipt of a			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated du	ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health. The ther a violation has been compliance with all rule provided at the tag ile number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item				
	that may result from orders provided tha the Department with	n non-compliance with these t a written request is made to hin 15 days of receipt of a				
	You have agreed to receipt of State lice the Minnesota Depa Informational Bullet <http: www.health.<br="">fobul.htm&gt; The St delineated on the a</http:>	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at state.mn.us/divs/fpc/profinfo/in ate licensing orders are				
_ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE 09/13/17

Electronically Signed

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STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00407	B. WING		08/	17/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CROSSF	ROADS CARE CENTE	R	IILLAN STREE NGTON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 000	•	age 1 Ith orders being submitted to	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th corrected prior to e	Although no plan of correction ate Statutes/Rules, please rected" in the box available for n indicate in the electronic cess, under the heading le date your orders will be lectronically submitting to the				
	<ul> <li>Minnesota Department of Health.</li> <li>On August 14, 15, 16 and 17 2017, surveyors of this Department's staff, visited the above provide and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.</li> <li>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.</li> </ul>					
		Correction Orders using ag numbers have been				
	column entitled "IE statute/rule out of o "Summary Stateme and replaces the "T correction order. Th findings which are after the statement evidence by." Follo	number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUM "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00407	B. WING		08/17/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
CROSSF	ROADS CARE CENTE	R	IILLAN STRE NGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			9/20/17
		omprehensive plan of care I personnel involved in the				
	by: Based on interview facility failed to follo side effect and/or T monitoring for 4 of R30) and antidepre	ent is not met as evidenced and document review, the w the care plan for medication ardive Dyskinesia (TD) 5 residents (R24, R21, R14, ssant monitoring for 1 out of 5 iewed for unnecessary		Corrected		
	Findings include:					
	of psychotropic me Interventions includ	ted 7/5/17, indicated R24's use dications as a focus. led monitoring for adverse ropic medications including	,			
	medical diagnosis i depression. R24's o (MDS) assessment Brief Interview for N	to facility on 6/14/17. R24's ncluded dementia and quarterly Minimum Data Set to dated 6/21/17, identified a Mental Status (BIMS) score of y impaired cognition.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00407	B. WING		08/	17/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
CROSSR	OADS CARE CENTE	R	IILLAN STREE NGTON, MN 5			
(X4) ID	SUMMARY STA	PROVIDER'S PLAN OF	CORRECTION	(X5)		
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 565	Continued From pa	ge 3	2 565			
2 000	<ul> <li>R24's current medication summary indicated an order for Risperidol (antipsychotic medication)</li> <li>0.25 milligrams (mg) by mouth at bedtime for unspecified psychosis; initiated on 6/14/17.</li> <li>Review of R24's medication administration record (MAR) from July 2017 to August 2017, indicated R24 was taking Risperidol daily.</li> <li>A review of R24's chart did not reveal a DISCUS (Dyskinesia Identification System: Condensed User Scale) had been completed to monitor the side effects of the Risperidol since admission.</li> <li>R21's care plan dated 5/21/17, indicated R21's use of antidepressant medications as a focus. Interventions included monitor/document for side effects and effectiveness.</li> </ul>					
	medical diagnosis i R21's quarterly MD	to facility on 5/28/15. R21's ncluded major depression. S assessment dated 8/1/17, core of 8 indicating moderately	,			
	order for Haloperide 0.25 milligrams(mg depression/mood; i R21's medication a from July 2017 to A was taking Risperid	cation summary, indicated an ol (antipsychotic medication) ) by mouth daily for nitiated on 6/21/16. Review of dministration record (MAR) ugust 2017, indicated R21 dol as ordered. R21's current ry also indicated an order for				
	Sertaline (antidepre mouth daily for dep 11/10/16, which wa order of Sertaline 1 depression/mood. I	essant medication) 150 mg by ression/mood; initiated on s an increase from previous 00 mg by mouth daily for Review of R21's medication rd (MAR) from July 2017 to				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00407	B. WING		08/17/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
CROSSR	OADS CARE CENTE	R	NGTON, MN 🗧			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
2 565	Continued From pa	age 4	2 565			
	and Sertaline as or	dered.				
	completed to moni Haloperidol. R21's monitoring docume medication increas During interview or director of nursing orders for side effe documentation in F 8/17/17, at 8:08 a.r DISCUS assessme admission, starting medication, when t or every 6 months. the DON verified n been completed sin facility. The DON w	n 8/16/17, at 2:31 p.m. the (DON) stated she did not see ect monitoring or R21's chart. The next day on m. the DON stated a baseline ent should be done upon a new antipsychotic there was a significant change Later that day at 11:10 a.m., o DISCUS assessment had nce R24 had been admitted to was not able to find any t a DISCUS had been	t			
	Order Report dated administer Celexa depression/mood;	on 4/10/08, and the Physician d 8/17/17, directed staff to 10 mg by mouth (PO) daily for initiation on 8/1/17, and PO at bed time for delusional nizophrenia.				
	identified R14 with depression and ps psychotropic medic	essment (CAA) dated 2/5/17, diagnoses of "schizophrenia, ychosis" which required cations prescribed by the der. It also indicated R14 was Dyskinesia.				
pposota D	used psychotropic	ed 5/5/17, indicated R14 had medications to manage ression, schizophrenia,				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00407	B. WING		08/	17/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
CROSSR	ROADS CARE CENTE	R	IILLAN STREE NGTON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	ige 5	2 565			
	antipsychotic medic and to monitor side medication every sl 4/28/17, also indica disorder and staff w medication as orde document the side medication; howeve documentation Risp adequately monitor On 8/16/17, at 8:20 stated they do not h system; stating, "we	peridone and Celexa were				
	MDS dated 5/19/17 non-Alzheimer's de identified that R30 v antipsychotic medic The MDS dated 5/1 rarely/never unders term memory probl impaired in decision	on 11/23/14. R30's quarterly r, included diagnoses of mentia and depression, and was prescribed both an cation and an antidepressant. 19/17, indicated R30 was stood, had a short and long em and was moderately n making. The quarterly MDS had no behaviors and no				
	antidepressants an for depression, deli and her behaviors/r	23/16, indicated R30 was on d an antipsychotic medication rium and to help with anxiety mood. The CAA also indicated psychotropic drug side				
	on antidepressants	rs 8/1/17, indicated R30 was Remeron 7.5 mg, Zoloft 25 tic Risperdal 0.25 mg.				

Iinnesota Department of He TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	00407	B. WING		08/	17/2017
AME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ROSSROADS CARE CENTE	R	MILLAN STREE			
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565 Continued From pa	ge 6	2 565			
	igust 2017 MAR indicated R30 al, Remeron and Zoloft daily.	)			
for side effects and monitor and docum reactions of PSYC tardive dyskinesia a plan also indicated, ordered. Monitor/do	ed 12/13/16, indicated: Monito effectiveness Q-SHIFT and ent PRN any adverse HOTROPIC medications for and other reactions. R30's care "Administer medications as bocument for side effects and for Pharmacy to review				
assisted with staff,	p.m. R30 was observed walker, and transfer belt to a g room where music was ors were exhibited.				
	al records verified the last I for R30 was 10/19/16, with a				
	ered nurse (RN)-C stated R30 behaviors but might get vhile.				
DISCUS for TD mo at baseline before a started, with signific	a.m. the DON stated a nitoring should be completed antipsychotic medication cant dosage changes, and at stated, "But we complete ( months."				
(ADON) stated she	7/17, the assistant DON completed DISCUS for sion for a baseline and then				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
		00407	B. WING		08/	17/2017				
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE						
CROSSROADS CARE CENTER 965 MCMILLAN STREET WORTHINGTON, MN 56187										
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE				
2 565	Continued From pa	ige 7	2 565							
	expected staff to fo	llow residents' care plans.								
	Antipsychotic Media Nursing staff shall r the following side e consequences of a	provided by the facility cation Use, indicated: " 14. monitor for and report any of ffects and adverse ntipsychotic medications to the n: tardive dyskinesia"	9							
	Comprehensive i comprehensive car measurable objecti resident's medical, psychological need resident f. Identify are responsible for	vided by the facility Care Plans ndicated, "An individualized re plan that includes ves and timetables to meet the nursing, mental and s is developed for each y the professional services that each element of care; i. cognized standards of practice and conditions"	e							
	director of nursing of system to educate system to ensure s directed by the writ	THOD OF CORRECTION: The or designee could develop a staff and develop a monitoring taff are providing care as ten plan of care. The director nee could monitor for								
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One								
2 570	MN Rule 4658.040 Plan of Care; Revis	5 Subp. 4 Comprehensive sion	2 570			9/20/17				
	care must be review interdisciplinary tea physician, a registe	A comprehensive plan of wed and revised by an m that includes the attending red nurse with responsibility d other appropriate staff in								

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED	
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IAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY,	STATE, ZIP CODE	1 00.		
ROSSR	OADS CARE CENTE	R					
040 15		WOR I HI	NGTON, MN	56187 PROVIDER'S PLAN OF C		()(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 570	Continued From pa	ge 8	2 570				
	and, to the extent participation of the guardian or chosen quarterly and within	mined by the resident's needs, practicable, with the resident, the resident's legal representative at least a seven days of the revision of resident assessment required subpart 3, item B.					
	by: Based on observative review, the facility f to identify the need repositioning/transf	ent is not met as evidenced ion, interview and document ailed to revise the plan of care for assistive devices for erring from bed for 1 of 3 iewed for accidents and who ails.		Corrected			
	Findings include:						
		on 8/16/17, at 11:34 a.m. /4 side rails bilaterally on the on.					
	observed in the up nursing (DON) look surveyor. It was not side of the bed had the bed outward. The borderline," referrin would ask mainten the side rail. Furthe assessments were quarterly, and with changes. The DON	p.m. R37's side rail was position. The director of ted at the rail with the ted the quarter rail on the door significant movement from he DON stated, "this is g to safety, and stated she ance to see if he could tighten tr, the DON stated side rail completed upon admission, medication and mobility also stated the side rail y checked for safety with each nt.					
	R37's annual Minim	num Data Set (MDS) dated					

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		SURVEY PLETED
		00407	B. WING		08/17/2017	
NAME OF I	PROVIDER OR SUPPLIER		I DRESS, CITY, SI	ATE, ZIP CODE	00/	
CROSSE	ROADS CARE CENTE	965 MCM	ILLAN STREE	т		
		WORTHIN	IGTON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	age 9	2 570			
	had short and long had moderately im MDS also indicated disorganized thinki behaviors and no r indicated R37 requ for locomotion on u Area Assessment ( R37 had advanced assistance with act also indicated R37 at times needed sta unsteadiness. R37's careplan dat able to transfer ind and stand by or lim indicated R37 was bed. However, the use of a quarter (1/					
	on 8/16/17, at 1:53 required staff assis R37 had dementia	with nursing assistant (NA)-B p.m., NA-B verified R37 stance to walk. NA-B stated but self transferred and side rail to get out of bed.				
	The facility's undate Comprehensive Ca individualized comp includes measurab meet the resident's psychological need resident f. Identifi are responsible for	ed policy regarding are Plans indicated, "An orehensive care plan that le objectives and timetables to a medical, nursing, mental and ls is developed for each y the professional services that each element of care; i.				
nnesota D	for problem areas a Assessments of re	cognized standards of practice and conditions 8. sidents are ongoing and care is information about the				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00407	B. WING	B. WING		17/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
CROSSF	ROADS CARE CENTE	R	IILLAN STREE NGTON, MN 5			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 570	Continued From pa	ge 10	2 570			
	resident and the res	sident's condition change"				
	DON or designee c procedures or facili plan development . educated regarding designee could dev	HOD OF CORRECTION: The ould review any policies, ty processes for resident care Appropriate staff could be any changes. The DON or elop a system to monitor the revisions are completed				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one				
21530	A. The drug regim reviewed at least m currently licensed b This review must be Appendix N of the S Surveyor Procedure Requirements in Lo the Department of H Health Care Finance This standard is ind available through th system. It is not su B. The pharma irregularities to the and the attending p must be acted upor physician visit, or so pharmacist. For pu upon" means the ac report and the signi of nursing services C. If the attend	A.B.C Drug Regimen Review en of each resident must be onthly by a pharmacist y the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, ing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan bject to frequent change. cist must report any director of nursing services hysician, and these reports n by the time of the next poner, if indicated by the irposes of this part, "acted cceptance or rejection of the ng or initialing by the director and the attending physician. ing physician does not concur				9/20/17

	NT OF DEFICIENCIES	CAITH (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION		E SURVEY PLETED
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		00407	B. WING		08/17/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
CROSSE	ROADS CARE CENTE	R	ILLAN STRE			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CO	DRRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLET DATE
21530	Continued From pa	age 11	21530			
	pharmacist believe being adversely aff refer the matter to if the medical direc physician. If the m the attending physi justification for the physician does not must be referred for assessment and as by part 4658.0070. the medical director must refer the matt	ate justification, and the s the resident's quality of life is ected, the pharmacist must the medical director for review tor is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter or review to the quality ssurance committee required If the attending physician is or, the consulting pharmacist ter directly to the quality ssurance committee.				
	by: Based on observat review, the facility f recommendations through with for 4 of R21, R14 and R30 medications. Findings include: R24 was admitted diagnoses (dx) incl depression. R24's (MDS) assessment Brief Interview for M	ent is not met as evidenced ion, interview and document failed to ensure pharmacy were identified, and or followed of 5 residents reviewed (R24, ) who utilized psycho active on 6/14/17, and had medical uding dementia and quarterly Minimum Data Set t dated 6/21/17, identified a Mental Status (BIMS) score of		Corrected		
	cognition. R24's current medi physician order for medication) 0.25 m	sident had severely impaired cation summary indicated a Risperidol (antipsychotic illigrams (mg) by mouth at cified psychosis; initiated on				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CROSSE	ROADS CARE CENTE	R	MILLAN STREE			
		WORTHI	NGTON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 12	21530			
		R24's medication rd (MAR) from July 2017 17, indicated R24 was taking				
	completed to monit Risperidol since ad assessment used t associated with the medications (Dyski Condensed User S	reveal a DISCUS had been tor the side effects of the mission. DISCUS-an o identify side effects a use of antipsychotic nesia Identification System: cale (DISCUS). There was no acist (CP)recommendation sight.				
	medical diagnosis i R21's quarterly MD	to facility on 5/28/15. R21's included major depression. IS assessment dated 8/1/17, core of 8 indicating moderately	,			
	order for Haloperid 0.25 mg orally dail initiated on 6/21/16 July 2017 through A Risperidol was adm The current medica an order for Sertalii 150 mg by mouth of initiated on 11/10/1 previous order of S for depression/moo	cation summary indicated an ol (antipsychotic medication) y for depression/mood; . Review of R21's MAR from August 2017, indicated ninistered daily as ordered. ation summary also identified ne (antidepressant medication daily for depression/mood; 6, which was an increase from pertaline 100 mg by mouth daily od. Review of R21's MAR august 2017 indicated both given as ordered.				
	monitor the side eff chart did not revea	a DISCUS assessment, to fects of the Haloperidol. R21's I side effect monitoring ertaline following medication				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
CROSSF	ROADS CARE CENTE	R	ILLAN STREE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	CTION SHOULD BE CO THE APPROPRIATE	
21530	Continued From pa	age 13	21530			
	increase.					
	indicated a DISCU available in the cha notes from CP-A a of DISCUS assess	rom CP-B dated 12/2/16, S assessment was not art. Subsequent pharmacy nd CP-B did not address lack ment. Pharmacy notes from dress lack of side effect aline.				
	director of nursing identify side effect	n 8/16/17, at 2:31 p.m. the (DON) stated she did not monitoring for the identified as documentation evident in				
	baseline DISCUS a upon admission, up prescribed antipsy change and/or eve 11:10 a.m., the DO assessment had be admission and was	confirm a DISCUS had been				
	stated he generally DISCUS be conduc Diskynesia). CP-A CP-B during Augus conducted the pha	n 8/17/17, at 10:38 a.m. CP-A recommended quarterly cted to watch for TD (Tardive stated he had only filled in for st, but that CP-B usually rmacy reviews for this facility. uld have CP-B call back, but ed.				
	Physician Order Restaff to administer	to facility on 4/10/08. R14's eport dated 8/17/17, directed Celexa 10 mg by mouth (PO) n/mood with a start date of				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
CROSSE	ROADS CARE CENTE	R	ILLAN STREE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CEACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION)EGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE DEFICIENCY				(X5) COMPLET DATE
21530	8/1/17, and Risperi delusional related t	done 2 mg, PO at bed time for o other schizophrenia	21530			
	identified diagnoses depression and psy psychotropic medic	ssessment (CAA) 2/5/17, s of "schizophrenia, /chosis" which required :ations prescribed by the ler. It also indicated R14 was Dyskinesia.				
	medication regimer "takes citalopram 1 record, the medicat federal law to evalu reduction. The CP to no depression an treatment". Howeve through whether the	sultant pharmacist's in dated 4/3/17, stated R14 0 mg daily." According to this tion was due per state and late the potential dose also stated R14 has "minimal and may no longer require er, the CP did not follow e physician had acted upon ons pharmacist was made to				
	Attending Physician revealed the reside long period of time if you still desire be [R14] OR if a DC [c However, the there determine whether	tant note titled "Note to h/Prescriber" dated 3/7/17, ent was on Benztropine for a and indicated: "please assess nefit of this medication for liscontinue] is appropriate". was no follow through to the physician had acted upon on the pharmacist made to the				
	facility had a syster pharmacist's recom through. However, been missed for R <sup>2</sup> coordinator should	a.m. the DON indicated the n in place to assure the mendations were followed she acknowledged this had 14 and stated the resident care have given the o the physician for review. The				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
0		00407	B. WING		08/17/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
CROSSR	OADS CARE CENTE	R	ILLAN STREE			
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	COMPLET DATE
21530	Continued From pa	age 15	21530			
	March and April [re addressed." Furthe they did not have s effect for psychoac On 8/17/17, at 10:5 Avera Long- Term had given recomm medications. How The surveyor gave with questions surv explanation why the	same issue occurred when the commendations] were not ermore, the DON admitted ystem in place to monitor side tive medication. 55 a.m. a call was placed to pharmacy to reach CP-B who endations related to R14's ever, CP-B was unavailable. email address to CP-A, and reyor had in order to get e recommendations were not to email was received from				
	R30's quarterly MD Dx of Non-Alzheim and indicated R30 medication and an dated 5/19/17, indic understood, had a problem and was n making. The quarter	to the facility on 11/23/14. DS dated 5/19/17, included a er's Dementia and Depression, was taking an antipsychotic antidepressant. The MDS cated R30 was rarely/never short and long term memory noderately impaired in decision erly MDS also indicated R30 with no rejection of cares.				
	antidepressants an for depression, deli anxiety and her bel	1/23/16, indicated R30 was on ad an antipsychotic medication irium Dx and to help with haviors/mood. The CAA also at risk for psychotropic drug				
	on antidepressants	ders 8/1/17, indicated R30 was Remeron 7.5 mg, Zoloft 25 otic Risperdal 0.25 mg.				
		ugust 2017 MAR indicated R30 Ial, Remeron, and Zoloft daily.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	00407		B. WING		08/17/2017	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE		
CROSSE	ROADS CARE CENTE	R	MILLAN STREE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 16	21530			
	R30's careplan dated 12/13/16, indicated Monitor for side effects and effectiveness Q-SHIFT and monitor and document PRN any adverse reactions of PSYCHOTROPIC medications for tardive dyskinesia and other reactions. R30's careplan also indicated, "Administer medications as ordered. Monitor/document for side effects and effectiveness." and for Pharmacy to review monthly.					
	On 8/16/17, at 1:48 p.m. R30 was observed assisted with staff, walker and transfer belt to a recliner in the dining room where music was playing.					
		At 2:13 p.m. medical records verified last DISCUS completed for R30 was 10/19/16, with a score of zero.				
		ered nurse (RN)-C stated R30 aviors and might get anxious				
	for TD monitoring s baseline before and with significant dos	a.m. DON stated a DISCUS should be completed at tipsychotic medication started, age changes and at least d, "But we complete them here				
		ant DON (ADON) stated she S on admission for baseline hs.				
	just filled in for the monthly medication recommendation for	59 a.m. CP-A stated he had regular CP-B on 8/1/17, for the n review and had not made a or a DISCUS to be completed ad he did not believe he had				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		00407	B. WING		08/17/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
CROSSF	ROADS CARE CENTE	R	ILLAN STREE			
			NGTON, MN 5	PROVIDER'S PLAN OF		(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 17	21530			
		given any recommendation for any resident at the facility to have TD monitoring completed.				
		′ p.m. DON stated she llow residents' careplans.				
	and CP-B's docum indicated no recom	Review of CP-A's documentation dated 8/1/17, and CP-B's documentation dated 7/3/17, ndicated no recommendation for side effects and/or TD monitoring was made.				
	Medication Use, ind monitor for side eff dyskinesia (TD).". monitor for and rep effects and adverse	cations to the Attending				
	policy, indicated the supply a written rep to the attending phy assessment and m the resident." 2. must supply a writte found to the attendi medical director an 5 working days of e acted upon 4. The within 35 days of re addressed by the a attempts) within the	ted Consultant Pharmacist e consultant pharmacist must port of any irregularities found ysician including psychoactive onitoring to meet the needs of The consultant pharmacist en report of any irregularities ing physician, the facility's d the director of nursing within exits. These reports must be e reports shall be acted upon eceipt 6. Any irregularity not ttending physician (after 3 e 35 day time frame will be edical director for action"				
	6/15, Consultant Pr Requirements indic	v provided by the facility dated narmacist Services Provider cated, " F. Specific activities pharmacist performs includes,				

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING.			
	00407		B. WING		08/	17/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
CROSSF	ROADS CARE CENTE	R	IILLAN STREE NGTON, MN 5			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE DATE
21530	Continued From pa	ge 18	21530			
	responsible prescri	: 2) Communicating to the ber and the facility leadership nendations for changes in and monitoring"				
	administrator, direct consulting pharmatic policies and proced medication usage. educated as necess pharmacist's review with the pharmacist reviews on a regula	THOD OF CORRECTION: The tor of nursing (DON) and sist could review and revise lures for proper monitoring of Nursing staff could be sary to the importance of the v. The DON or designee, along t, could audit medication ar basis to ensure compliance, idings to the facility's quality ee.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21535	MN Rule4658.1315 Drug Usage; Genei	subp.1 ABCD Unnecessary ral	21535			9/20/17
	must be free from u unnecessary drug i A. in excessive therapy; B. for excessiv C. without adec D. in the prese which indicate the o discontinued. In addition to the d part 4658.1310, the with provisions in th Code of Federal Re 483.25 (1) found in	al. A resident's drug regimen unnecessary drugs. An s any drug when used: dose, including duplicate drug e duration; quate indications for its use; or nce of adverse consequences dose should be reduced or rug regimen review required in e nursing home must comply he Interpretive Guidelines for egulations, title 42, section Appendix P of the State , Guidance to Surveyors for				

R7NS11

If continuation sheet 19 of 34

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00407	B. WING		08/17/201	
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
ROSSR	OADS CARE CENTE	R	IILLAN STRE NGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 19	21535		,	
	Department of Hea Health Care Finance This standard is inc available through th	acilities, published by the lith and Human Services, cing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan ate Law Library. It is not change.				
	by: Based on observat review, the facility f medications were r and/or adverse effe with the consulting	for 4 of 5 residents (R24, R21,		Corrected		
	Findings include:					
	diagnoses (dx) incl depression. R24's o (MDS) assessment Brief Interview for M	on 6/14/17, and had medical uding dementia and quarterly Minimum Data Set t dated 6/21/17, identified a Mental Status (BIMS) score of sident had severely impaired				
	physician order for medication) 0.25 m bedtime for unspect 6/14/17. Review of administration reco	cation summary indicated a Risperidol (antipsychotic iilligrams (mg) by mouth at cified psychosis; initiated on R24's medication ord (MAR) from July 2017 17, indicated R24 was taking				
	R24's chart did not	reveal a DISCUS had been				

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STATEME	o <u>ta Department of He</u> NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00407	B. WING		08/	17/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
CROSSE	ROADS CARE CENTE	R	IILLAN STREE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
21535	Continued From pa	age 20	21535			
	Risperidol since ad assessment used t associated with the medications (Dyski Condensed User S R21 was admitted f medical diagnosis i R21's quarterly MD identified a BIMS s impaired cognition. R21's current medi order for Haloperid 0.25 mg orally dail initiated on 6/21/16 July 2017 through / Risperidol was adm The current medica an order for Sertalii 150 mg by mouth of initiated on 11/10/1 previous order of S for depression/moo from July 2017 to A medications were g R21's chart lacked monitor the side effic chart did not reveal documented for Ser increase. A pharmacy note fr (CP)-B dated 12/2/ assessment was m Subsequent pharm CP-B did not addre	to facility on 5/28/15. R21's included major depression. S assessment dated 8/1/17, core of 8 indicating moderately cation summary indicated an ol (antipsychotic medication) y for depression/mood; . Review of R21's MAR from August 2017, indicated ninistered daily as ordered. ation summary also identified ne (antidepressant medication) daily for depression/mood; 6, which was an increase from tertaline 100 mg by mouth daily od. Review of R21's MAR august 2017 indicated both given as ordered. a DISCUS assessment, to fects of the Haloperidol. R21's I side effect monitoring ertaline following medication om consulting pharmacist 16, indicated a DISCUS ot available in the chart. acy notes from CP-A and				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
00407		00407	B. WING	B. WING		17/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CROSSR	OADS CARE CENTE	R	MILLAN STREE NGTON, MN 🗧			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 21	21535			
	not address lack of Sertaline.	f side effect monitoring for				
	During interview on 8/16/17, at 2:31 p.m. the director of nursing (DON) stated she did not identify side effect monitoring for the identified medications nor was documentation evident in R21's chart.					
	baseline DISCUS a upon admission, up prescribed antipsy change and/or eve 11:10 a.m., the DO assessment had be admission and was	confirm a DISCUS had been				
	Medication Use ind	ated facility policy Antipsychotic licated the nursing staff would fects including tardive				
	Order Report dated administer Celexa depression/mood;	on 4/10/08, and the Physician d 8/17/17, directed staff to 10 mg by mouth (PO) daily for initiation on 8/1/17, and PO at bed time for delusional nizophrenia.				
	identified R14 with depression and psy psychotropic medic	essment (CAA) dated 2/5/17, diagnoses of "schizophrenia, ychosis" which required cations prescribed by the der. It also indicated R14 was Dyskinesia.				
		sultant pharmacist's				
nesota De ATE FORI	epartment of Health VI		<sup>6899</sup> R	7NS11	If continuati	on sheet 22

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
004		00407	B. WING	B. WING		17/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CROSSR	OADS CARE CENTE	R	MILLAN STREE			
			NGTON, MN 5		0000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21535	Continued From pa	age 22	21535			
	"takes citalopram 1 record, the medical federal law to evalu- reduction. The CP a to no depression and treatment". Howeve through the CP's re- Pharmacy consultar resident was on Be time. "please assess of this medication f [discontinue] is app	n dated 4/3/17, stated R14 0 mg daily." According to this tion was due per state and uate the potential dose also stated R14 has "minimal nd may no longer require er, the facility did not follow ecommendation. ant note dated 3/7/17, revealed enztropine for a long period of ss if you are still desired benefit for [R14] OR if a DC propriate". However, the facility gh the CP's recommendation.	t			
	used psychotropic behaviors of "depr psychosis". Staff we antipsychotic medic and to monitor side medication every si 4/28/17, also indica disorder and staff we medication as orde document the side medication; howeve	peridone and Celexa were				
	stated they do not h system; stating, "we	) a.m. registered nurse (RN)-D have a side effect monitoring e will put the side effect navior monitoring as soon as				
	DON indicated the	on 8/16/17, at 9:42 a.m. the facility had a system to ensure ommendation followed				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/17/2017	
	00407		B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
CROSSF	ROADS CARE CENTE	R	IILLAN STREE NGTON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
21535	Continued From pa	age 23	21535			
	through; however, it was missed and the resident care coordinator should have given the recommendation to the physician for review/response. "The same issue for March and April [recommendation] were not addressed." Furthermore, the DON admitted they did not have system in place to monitor side effect for psychoactive medication and stated, "I do accept that."					
	MDS dated 5/19/17 non-Alzheimer's de identified that R30 antipsychotic medie The MDS dated 5/7 rarely/never unders term memory probl impaired in decision	on 11/23/14. R30's quarterly 7, included diagnoses of ementia and depression, and was prescribed both an cation and an antidepressant. 19/17, indicated R30 was stood, had a short and long lem and was moderately n making. The quarterly MDS had no behaviors and no				
	antidepressants an for depression, deli and her behaviors/	23/16, indicated R30 was on ad an antipsychotic medication irium and to help with anxiety mood. The CAA also indicated psychotropic drug side				
	on antidepressants	rs 8/1/17, indicated R30 was Remeron 7.5 mg, Zoloft 25 tic Risperdal 0.25 mg.				
		ugust 2017 MAR indicated R30 lal, Remeron and Zoloft daily.				
	for side effects and monitor and docum	ed 12/13/16, indicated: Monitor l effectiveness Q-SHIFT and nent PRN any adverse HOTROPIC medications for				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00407	B. WING	B. WING		17/2017
PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
OADS CARE CENTE	R				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE	(X5) COMPLET DATE
Continued From pa	age 24	21535			
plan also indicated, ordered. Monitor/do	, "Administer medications as ocument for side effects and				
assisted with staff, walker, and transfer belt to a ecliner in the dining room where music was					
for TD monitoring s baseline before ant with significant dos	should be completed at tipsychotic medication started, age changes, and at least				
(ADON) stated she	completed DISCUS for				
just filled in for the monthly medication recommendation for for R30. CP-A state given any recomme	regular CP-B on 8/1/17, for the n review and had not made a or a DISCUS to be completed ad he did not believe he had endation for any resident at the				
	OF CORRECTION PROVIDER OR SUPPLIER <b>COADS CARE CENTE</b> SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From particular tardive dyskinesia a plan also indicated, ordered. Monitor/do effectiveness." and monthly. On 8/16/17, at 1:48 assisted with staff, recliner in the dinin playing. At 2:13 p.m. medic DISCUS completed score of zero. At 2:16 a.m. register had not many behar once in a while. On 8/17/17, at 8:32 for TD monitoring se baseline before and with significant dos annually, and state every six months." At 9:20 a.m. on 8/1 (ADON) stated sher residents on admise every six months. On 8/17/17, at 10:55 just filled in for the monthly medication recommendation for for R30. CP-A state given any recommendation for for R30. CP-A state	OF CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         00407         STREET AD         965 MCM         COADS CARE CENTER       STREET AD         SUMMARY STATEMENT OF DEFICIENCIES         (EACH DEFICIENCY MUST BE PRECEDED BY FULL         REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 24         tardive dyskinesia and other reactions. R30's care         plan also indicated, "Administer medications as         ordered. Monitor/document for side effects and         effectiveness." and for Pharmacy to review         monthly.         On 8/16/17, at 1:48 p.m. R30 was observed         assisted with staff, walker, and transfer belt to a         recliner in the dining room where music was         playing.         At 2:13 p.m. medical records verified last         DISCUS completed for R30 was 10/19/16, with a         score of zero.         At 2:16 a.m. registered nurse (RN)-C stated R30         had not many behaviors and might get anxious         once in a while.         On 8/17/17	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:	OF CORRECTION     IDENTIFICATION NUMBER:     A. BUILDING:       00407     B. WING       PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       965 MCMILLAN STREET     965 MCMILLAN STREET       WORTHINGTON, MN 56187     SUMMARY STATEMENT OF DEFICIENCIES       SUMMARY STATEMENT OF DEFICIENCIES     ID       REGULATORY OR LSC IDENTIFYING INFORMATION)     ID       PREFIX     TAG       Continued From page 24     21535       tardive dyskinesia and other reactions. R30's care plan also indicated, "Administer medications as ordered. Monitor/document for side effects and effectiveness." and for Pharmacy to review monthly.       On 8/16/17, at 1:48 p.m. R30 was observed assisted with staff, walker, and transfer belt to a recliner in the dining room where music was playing.       At 2:13 p.m. medical records verified last DISCUS completed for R30 was 10/19/16, with a score of zero.       At 2:16 a.m. registered nurse (RN)-C stated R30 had nut many behaviors and might get anxious once in a while.       On 8/17/17, at 8:32 a.m. DON stated a DISCUS for TD monitoring should be completed at baseline before antipsychotic medication started, with significant dosage changes, and at least annually, and stated, "But we complete them here every six months."       At 9:20 a.m. on 8/17/17, the assistant DON (ADON) stated she completed DISCUS for residents on admission for a baseline and then every six months.       On 8/17/17, at 10:59 a.m. CP-A stated he had just filled in for the regular CP-B on 8/11/17, for the monthly medication review and had not made a recommendation for a DISCUS to be c	OF CORRECTION       IDENTIFICATION NUMBER:       A BUILDING:       08/         00407       B. WING       08/         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL       PREVIDER STREET         WORTHINGTON, NN 56187       D         Continued From page 24       ID         tardive dyskinesia and other reactions. R30's care       DEFICIENCY MUST BE effected and other reactions as ordered. Monitor/idocument for side effects and effectiveness." and for Pharmacy to review monthly.         On 8/16/17, at 1:48 p.m. R30 was observed assisted with staff, walker, and transfer belt to a recliner in the dining room where music was playing.       At 2:15 a.m. registered nurse (RN)-C stated R30 had not many behaviors and might get anxious once in a while.         On 8/17/17, at 3:32 a.m. DON stated a DISCUS for TD monitoring should be completed at baseline before antipsycholic medication started, with significant dosage changes, and at least annually, and stated, "Eut we complete them here every six months."       At 9:20 a.m. of 8/17/17, th eassistant DON (ADON) stated she completed DISCUS for residents on admission for a baseline and then every six months.         On 8/17/17, at 10:59 a.m. CP-A stated he had just filled in for the regular CP-B on 8/1/17, for the monthly medication for a DISCUS to be completed for R30. CP-A stated he add not made a recommedation for a DISCUS to be completed for R30. CP-A stated he had given any recommedation for a baseline and then every six months.

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		00407	B. WING		08/	17/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CROSSR	OADS CARE CENTE	R	MILLAN STREE			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21535	Continued From pa	age 25	21535			
	expected staff to for	llow residents' care plans.				
	Antipsychotic Medi Nursing staff shall the following side e consequences of a	provided by the facility cation Use indicated, " 14. monitor for and report any of effects and adverse intipsychotic medications to the n: tardive dyskinesia"	9			
	Medication Use" in medications will be guidelines listed	policy "Psychotropic dicated, "All psychotropic used within the dosage Or clinical justification will be sages that exceed the listed than 48 hours."				
	The director of nur- in-service all staff r on the need to ens conducted to identi manner. They cou charts to ensure th	THOD OF CORRECTION: sing or pharmacist could esponsible for medication use ure adequate monitoring is fy adverse effects in a timely Id initiate a random review of is happened, and could report ity's quality assurance				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty One				
21565	MN Rule 4658.132 Medications Self A	5 Subp. 4 Administration of dmin	21565			9/20/17
	self-administer me resident assessme care as required in 4658.0405 indicate	ninistration. A resident may dications if the comprehensive int and comprehensive plan of parts 4658.0400 and this practice is safe and there om the attending physician.				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
		00407	B. WING		08/17/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
CROSSF	ROADS CARE CENTE	R	IILLAN STRE			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLET DATE
21565	Continued From pa	age 26	21565			
	This MN Requirem by:	ent is not met as evidenced				
	Based on observat review, the facility f had been complete of medication (SAM	ion, interview and document ailed to ensure an assessment of for safe self-administration /) for 1 of 2 residents (R46) inistering a nebulizer		Corrected		
	Findings include:					
	assessment dated interview for menta The activities of da all activities as exter mobility, transfer, w locomotion on and	num Data Set (MDS) 6/14/17, indicated a brief I status (BIMS) score of 12, ily living assessment identified ensive assistance (bed valk in room and corridor, off unit, dressing, toilet use ne) with the exception of oded independent.				
	Suspension 0.5 mil (ml); inhale orally tv idiopathic pulmonal lungs that causes p Additionally, R46 al order for DuoNeb S to be given for shor medication adminis	ician orders included Pulmicort ligrams (mg) per 2 milliliters wo times a day related to ry fibrosis (scar tissue in the progressive damage). Iso received an as needed Solution 0.5-2.5; 3 mg per 3 ml, rtness of breath, the stration record indicated this en administered three times				
nnesota D	enter R46's room to treatment. RN-B fill medication, and ha then stated to the s nebulizer and the re	a.m. RN-B was observed to o administer a nebulizer led the nebulizer with the nded R46 the mask. RN-B surveyor that she starts the esident will then be o the mask on independently.				

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00407	B. WING		08/	17/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE	•	
CROSSR	OADS CARE CENTE	R	ILLAN STREE			
			NGTON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21565	Continued From pa	ge 27	21565			
	face while the nebuleft the room to compass. Several minut the room to remove treatment. At that ti to his face, which harrived. R46 was has the treatment was comnebulizer chamber, and left the mask a paper towels. R46's self-administ 6/7/17, indicated R4 or functional ability medications. In an interview with 8/16/17, at 2:45 p.m and out of the facili succeed at home". she had completed self-administration resident's readmiss the SAM assessment determine whether medications and to cognitive ability to p Coordinator further having done any full	to hold the mask up to his dizer treatment began. RN-B tinue with the medication utes later the RN-B returned to a the nebulizer mask and me, R46 still had the mask up e removed when the nurse here to state that he thought inished. RN-B verified the plete by examining the she then rinsed the chamber nd chamber to air dry on ration assessment dated 46 did not have the cognitive to self-administer his the MDS Coordinator on n. she stated R46 had been in ty due to being "unable to The MDS Coordinator stated the initial brief assessment for of medications following the sion to the facility. She said ent had been conducted to R46 wished to self-administer determine whether he had the perform the task. The MDS stated she could not recall rther assessment of R46's elf-administration of				
	8/17/17, at 9:45 a.m assessment should	sing stated during interview on n. that another SAM I have been conducted prior to to self administer the nebulizer				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED	
		00407	B. WING		08/	08/17/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
CROSSF	ROADS CARE CENTE	R	ILLAN STRE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21565	Continued From pa	ige 28	21565				
	Medications, indica may self-administe determined they we part of their overall practitioner will ass physical abilities, to is capable of self-ad SUGGESTED MET The director of nurs develop systems to and resident safety opportunities. The l educate all appropr The DON or design to ensure ongoing of	titled Self-Administration of ted residents of the facility r their medications if it was ere capable of doing so. "As evaluation, the staff and ess the resident's mental and o determine whether a resident dministering medications." THOD OF CORRECTION: ses (DON) or designee could o ensure regulatory compliance during self administration DON or desginee could riate staff on these systems. nee could develop monitoring compliance and share those lity's quality committee for lations.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One					
21665	MN Rule 4658.140	0 Physical Environment	21665			9/20/17	
	functional, comforta environment, allow	ust provide a safe, clean, able, and homelike physical ing the resident to use s to the extent possible.					
	by: Based on observat review, the facility f devices were asses of 3 residents revie	ent is not met as evidenced ion, interview and document ailed to ensure assistive ssed to ensure safe use for 2 wed for accidents (R37, R18) its whose environments were		Corrected			

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00407	B. WING		08/17	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
CROSSR	OADS CARE CENTE	R	IILLAN STREE NGTON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21665	Continued From pa	ge 29	21665			
	randomly reviewed potential environme	(R9, R27, R38, R42) for ental hazards.				
	Findings include:					
		on 8/16/17, at 11:34 a.m. /4 side rails bilaterally on the on.				
	observed in the up nursing (DON) look surveyor. It was no side of the bed had the bed outward. T borderline," referrin would ask maintena the side rail. Furthe assessments were quarterly, and with the changes. The DON should be physically side rail assessment					
	6/12/17, indicated F had short and long had moderately imp MDS also indicated disorganized thinkir behaviors and no re indicated R37 requi for locomotion on u Area Assessment ( R37 had advanced	num Data Set (MDS) dated R37 was rarely understood, term memory problems, and paired decision making. This R37 had inattention and ng, but experienced no ejection of cares. The MDS ired limited assistance of staff nit. The corresponding Care CAA) dated 6/12/17, indicated dementia and needed staff ivities of daily living. The CAA				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00407	B. WING		08/	17/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
CROSSE	ROADS CARE CENTE	R	IILLAN STREE NGTON, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21665	R37's careplan date able to transfer inde and stand by or limi indicated R37 was a bed. However, the o use of a quarter (1/4 During an interview on 8/16/17 at 1:53 p required staff assist R37 had dementia l utilized the quarter s On 8/16/17, at 2:24 needed stand by as steady on her feet. her side rails to pull further stated if a re more than a little sh to fix. On 8/16/17, at 2:26 stated nurses did no assessments but th the assistant DON ( rail assessments. A Coordinator stated rail assessments sh whether they wante complete the side ra MDS Coordinator fu physically checked completed an asses were safe, and that the rail and the bed when a side rail was	<ul> <li>de 7/1/16, indicated R37 was ependently with supervision ted assist. The careplan also able to reposition herself in careplan did not include the 4) side rail.</li> <li>with nursing assistant (NA)-B o.m., NA-B verified R37 tance to walk. NA-B stated but self transferred and side rail to get out of bed.</li> <li>p.m. NA-A stated R37 used herself up from bed. NA-A stated R37 used herself up from bed. NA-A esident's side rails moved the would call the maintenance</li> <li>p.m. registered nurse (RN)-C ot complete the side rail at the MDS Coordinator and (ADON) completed the side to 2:31 p.m. the MDS when she completed the side to 4:31 p.m. the MDS when she completed the side to 4:31 p.m. the MDS when she completed the side to 4:31 p.m. the MDS when she completed the side to 4:31 p.m. the MDS when she completed the side to 4:31 p.m. the MDS when she completed the side to 4:31 p.m. the MDS when she completed the side to 4:31 p.m. the MDS when she completed the side to 4:31 p.m. the MDS when she completed the side to 4:31 p.m. the MDS when she completed the side to 4:31 p.m. the MDS when she completed the side to 4:31 p.m. the MDS when she completed the side to 4:31 p.m. the MDS when she completed the side to 5:31 p.m. the MDS when she completed the side to 5:31 p.m. the MDS when she completed the side to 5:31 p.m. the MDS when she completed the side to 5:31 p.m. the MDS when she completed the side to 5:31 p.m. the MDS when she completed the side to 5:31 p.m. the MDS when she completed the side to 5:31 p.m. the MDS when she completed the side to 5:31 p.m. the MDS when she completed the side to 5:31 p.m. the MDS when she completed the side to 5:31 p.m. the MDS when she completed the side to 5:31 p.m. the MDS when she completed the side to 5:31 p.m. the MDS when she completed the side to 5:31 p.m. the MDS when she completes the side to 5:31 p.m. the MDS when she completes the side to 5:31 p.m. the MDS when she completes the side to 5:31 p.m. the MDS when she completes the side to 5:31 p.m. the MDS when she comp</li></ul>				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00407	B. WING		08/	17/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
CROSSR	ROADS CARE CENTE	R	ILLAN STREE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21665	Continued From pa	age 31	21665			
	expectation was the physically checked	p.m. the DON stated her at side rails would be when assessed to ensure they N also stated would follow protocol.				
	much movement in	2 a.m. the DON stated too a side rail could cause for a resident attempting to getting up.				
	completed side rail quarterly, at the tim when there were m ADON stated she c	a.m. the ADON stated she assessments upon admission, be of a significant change, and bobility changes. However, the did not physically check the because it was not identified				
	On 8/17/17, at 10:0 herself in and out c	02 a.m. RN-B stated R37 gets of bed herself.				
	R18's cognition wa R18 needed staff a mobility. R18's CA/ had a balance define fracture and needed with transfers, toile	IDS dated 7/18/17, indicated s severely impaired and that assist with transfers and bed A dated 7/18/17, indicated R18 cit related to compression ad limited to extensive assist ting and ambulation. It was was at risk for falls with				
	used grab bars to r turning and reposit	ted 7/28/17, indicated R18 maximize independence with ioning in bed, and was able to vision using four wheeled				
		servation on 8/14/17, at 7:21 a rail was noted not to fit				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00407	B. WING		08/	17/2017
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
CROSSF	ROADS CARE CENTE	R	MILLAN STREE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21665	Continued From pa	age 32	21665			
	bed outward about	vas noted to move from the two inches. At the time of the tated to the surveyor, "That is em to fix."				
		a.m. R18 was observed to be /4 side rail up on the door side				
	DON went to R18's rail. The DON verif She stated, "What movement back an	a.m. the surveyor and the s room to look at the 1/4 side ied the 1/4 side rail was loose. concerns me most is the id forth". The DON stated there ion of the side rail and that it				
		of siderails revealed the that were not securely l:				
	in the up position o	on the door side was observed n 8/14/17, at 7:11 p.m. The rai ove from the mattress outward	I			
	in the up position o	on the door side was observed n 8/15/17, at 9:56 a.m. The rai ove from the mattress outward	I .			
	in the up position o	on the door side was observed n 8/15/17, at 9:59 a.m. The rai ove from the mattress outward	1			
	observed in up pos	n the door side of the bed was ition on 8/15/17, at 3:57 p.m. ved to move from the mattress inches.				

Minnesota Departr	nent of He	ealth				
STATEMENT OF DEFICIE AND PLAN OF CORREC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMPI	
		00407	B. WING		08/1	7/2017
NAME OF PROVIDER OF	R SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CROSSROADS CAP	RE CENTE	B	ILLAN STRE NGTON, MN			
PREFIX (EACH	DEFICIENC'	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
The admi designee procedure equipmer also be co equipmer	TED MET nistrator, could upo es related to ensur ompleted nt is in saf	age 33 THOD OF CORRECTION: director of maintenance, or date facility policies and to auditing and tracking care re it remains safe. Audits could to ensure resident care e operating condition. R CORRECTION: Twenty One	21665			
Minnesota Department of	Health					

_		AND HUMAN SERVICES		F539507.6	FORM	09/20/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	L ' '	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245395	B. WING _		08/	16/2017
NAME OF F	PROVIDER OR SUPPLIER		· [	STREET ADDRESS, CITY, STATE, ZIP CODE		
CROSSR	OADS CARE CENTE	R		965 MCMILLAN STREET WORTHINGTON, MN 56187		
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		LD BE	COMPLETION DATE
K 000	INITIAL COMMEN	rs	K 00	00		
	FIRE SAFETY					
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE ATION OF COMPLIANCE.				
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CC REGULATIONS H/	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	Minnesota Departn Fire Marshal Divisio Crossroads Care C compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National	Survey was conducted by the nent of Public Safety, State on. At the time of this survey, Center was found not to be in e requirements for participation aid at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association afety Code (LSC), Chapter 19 re Occupancies.				
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K Health Care Fire In	R THE FIRE SAFETY -TAGS) TO:		FPO	C	
	State Fire Marshal 445 Minnesota Stre St. Paul, MN 5510	Division eet, Suite 145				
	By email to:					
		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
Electron	ically Signed					09/13/2017

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

STATEMENT OF DEFICIENCIES       (X1) PROVIDER OUR PULENCUA IDENTIFICATION NUMBER       (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLER       245395       B. WING       08/16/2017         NAME OF PROVIDER OR SUPPLER       STREET ADDRESS, CITY, STATE, ZIP CODE 956 MCMILLAN STREET WORTHINGTON, MN 56187       08/16/2017         (X4) JD PREEK TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PROVIDERS OF ALA OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST INCOMPARIANTION)       K 000         K 000       Continued From page 1 (Marian.Whitney@state.mn.us> (mailto:Angela.Kappenman@state.mn.us> (mailto:Angela.Kappenman@state.mn.us> (THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:       K 000       I. A description of what has been, or will be, done to correct the deficiency.       Crossroads Care Center was constructed as follows: The original building was constructed as follows: The original building was constructed as follows: The original building was constructed as full basement, is fully was determined to be of Type II(111)			AND HUMAN SERVICES & MEDICAID SERVICES				09/20/2017 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       CROSSROADS CARE CENTER     965 MCMILLAN STREET       WORTHINGTON, MN 56187     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG     D PREFIX       REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG     CONSTREET CORRECTION SHOULD BE (CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG     PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX     CONSTREET CORRECTION SHOULD BE (CACS REFERENCY)     CONSTREET (EACH ORDER TO THE APPROPRIATE DEFICIENCY)       K 000     Continued From page 1 Marian. Whitney@state.mn.us> <mailto: marian.="" whitney@state.mn.us=""> <mailto: marian.="" whitney@state.mn.us=""> <mailto: marian.="" whitney@state.mn.us="">     K 000       THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:     K 000       1. A description of what has been, or will be, done to correct the deficiency.     Crossroads Care Center was constructed as follows: The original building was constructed as follows: The original building was constructed as full basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction.</mailto:></mailto:></mailto:>	STATEMENT	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,			
Ses MCMILLAN STREET WORTHINGTON, MN 56187       (X4) ID TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)     ID PREFIX TAG     ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     CORRECTION (Marian.Whitney@state.mn.us <mailto:marian.whitney@state.mn.us <mailto:marian.whitney@state.mn.us <mailto:marian.whitney@state.mn.us <mailto:marian.whitney@state.mn.us <mailto:marian.whitney@state.mn.us <mailto:marian.whitney@state.mn.us <mailto:marian.whitney@state.mn.us <mailto:marian.whitney@state.mn.us <mailto:marian.whitney@state.mn.us <mailto:marian.whitney@state.mn.us <mailto:marian.whitney@state.mn.us <mailto:marian.whitney@state.mn.us <mailto:marian.whitney@state.mn.us <mailto:marian.whitney@state.mn.us <mailto:marian.whitney@state.mn.us <mailto:marian.whitney@state.mn.us <mailto:marian.whitney@state.mn.us <mailto:marian.whitney@state.mn.us K 000       THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:     1. A description of what has been, or will be, done to correct the deficiency.     2. The actual, or proposed, completion date,     3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.     Crossroads Care Center was constructed as follows: The original building was constructed as follows: The original building was constructed as full basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction.     III basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction.</mailto:marian.whitney@state.mn.us </mailto:marian.whitney@state.mn.us </mailto:marian.whitney@state.mn.us </mailto:marian.whitney@state.mn.us </mailto:marian.whitney@state.mn.us </mailto:marian.whitney@state.mn.us </mailto:marian.whitney@state.mn.us </mailto:marian.whitney@state.mn.us </mailto:marian.whitney@state.mn.us </mailto:marian.whitney@state.mn.us </mailto:marian.whitney@state.mn.us </mailto:marian.whitney@state.mn.us </mailto:marian.whitney@state.mn.us </mailto:marian.whitney@state.mn.us </mailto:marian.whitney@state.mn.us </mailto:marian.whitney@state.mn.us </mailto:marian.whitney@state.mn.us </mailto:marian.whitney@state.mn.us 			245395	B. WING _		08/1	6/2017
WORTHINGTON, MN 56187         WORTHINGTON, MN 56187       SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ATION SHOULD BE (EACH CORRECTIVE ATION SHOULD BE CACH CORRECTIVE ATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLET (EACH CORRECTIVE ATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SHOULD SHOULD SHO	NAME OF I	PROVIDER OR SUPPLIER				CODE	
Matrix TXG       REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFX TXG       CCORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE       COMPLET DEFICIENCY         K 000       Continued From page 1 Marian. Whitney@state.mn.us <mailto:marian.whitney@state.mn.us <mailto:angela.kappenman@state.mn.us <mailto:angela.kappenman@state.mn.us <mailto:angela.kappenman@state.mn.us>       K 000         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.       .         1. A description of what has been, or will be, done to correct the deficiency.       2. The actual, or proposed, completion date.       .         3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.       Crossroads Care Center was constructed as follows: The original building was constructed as follows: The original building was constructed as follows: The 1968 Addition is one-story in height, has a full basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction.       Image: Construction</mailto:angela.kappenman@state.mn.us></mailto:angela.kappenman@state.mn.us </mailto:angela.kappenman@state.mn.us </mailto:marian.whitney@state.mn.us 	CROSSE	ROADS CARE CENTE	R				
Marian.Whitney@state.mn.us <mailto:marian.whitney@state.mn.us> and Angela.Kappenman@state.mn.us&gt; THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Crossroads Care Center was constructed as follows: The original building was constructed in 1953, is one-story in height, has a full basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1968 Addition is one-story in height, has a full basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction.</mailto:marian.whitney@state.mn.us>	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	ON SHOULD BE	COMPLETION
and spaces open to the corridors, which are monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 42 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: K 222 NFPA 101 Egress Doors K 222 9/20/17	K 222	Marian.Whitney@s <mailto:marian.wh Angela.Kappenmar <mailto:angela.kap THE PLAN OF COU DEFICIENCY MUS FOLLOWING INFO 1. A description of w to correct the defici 2. The actual, or pro 3. The name and/o responsible for corr prevent a reoccurre Crossroads Care C follows: The original building one-story in height, fire sprinkler protect of Type II(111) cons The 1968 Addition full basement, is full was determined to The facility has smo and spaces open to monitored for autor notification. The fac and had a census of The requirement at NOT MET as evide</mailto:angela.kap </mailto:marian.wh 	tate.mn.us itney@state.mn.us> and n@state.mn.us openman@state.mn.us> RRECTION FOR EACH T INCLUDE ALL OF THE ORMATION: what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. renter was constructed as g was constructed in 1953, is has a full basement, is fully ted and was determined to be struction; is one-story in height, has a lly fire sprinkler protected and be of Type II(111) construction. obte detection in the corridors o the corridors, which are matic fire department cility has a capacity of 50 beds of 42 at time of the survey. .42 CFR, Subpart 483.70(a) is nced by:				9/20/17
SS=F         FORM CMS-2567(02-99) Previous Versions Obsolete       Event ID: R7NS21       Facility ID: 00407       If continuation sheet Page 2			Obsolato Event ID, D7100		Equility ID: 00407	If continuation show	at Page 2 of 7

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/20/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245395	B. WING			08/1	16/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CROSSF	OADS CARE CENTE	R			65 MCMILLAN STREET /ORTHINGTON, MN 56187		
(X4) ID PREFIX T <b>A</b> G	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 222	Egress Doors Doors in a required equipped with a late use of a tool or key using one of the fol arrangements: CLINICAL NEEDS LOCKING Where special lock clinical security nee only one locking de each door and prov rapid removal of oc locks; keying of all all times; or other s to the staff at all tim 18.2.2.2.5.1, 18.2.2 SPECIAL NEEDS L Where special lock safety needs of the Clinical or Security being met. In additi electrical locks that upon loss of power protected by a supe system and the lock complete smoke de constantly monitore within the locked sp and detection syste doors upon activati 18.2.2.2.5.2, 19.2.2 DELAYED-EGRES ARRANGEMENTS Approved, listed de installed in accorda permitted on door a	means of egress shall not be ch or a lock that requires the from the egress side unless lowing special locking OR SECURITY THREAT ing arrangements for the eds of the patient are used, vice shall be permitted on visions shall be made for the cupants by: remote control of locks or keys carried by staff at uch reliable means available nes. 2.26, 19.2.2.2.5.1, 19.2.2.2.6 OCKING ARRANGEMENTS ing arrangements for the patient are used, all of the Locking requirements are on, the locks must be fail safely so as to release to the device; the building is ervised automatic sprinkler ked space is protected by a etection system (or is ed at an attended location bace); and both the sprinkler erms are arranged to unlock the on. 2.2.5.2, TIA 12-4 S LOCKING		222			

Event ID: R7NS21

Facility ID: 00407

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			T	. 0938-039
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
	245395		B. WING		08/16/2017	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>-</u>	
CROSSI	ROADS CARE CENTE	R		965 MCMILLAN STREET WORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
K 222	fire detection syste automatic sprinkler 18.2.2.2.4, 19.2.2.2 ACCESS-CONTRO ARRANGEMENTS Access-Controlled installed in accorda permitted. 18.2.2.2.4, 19.2.2.2 ELEVATOR LOBB ARRANGEMENTS Elevator lobby exit accordance with 7. door assemblies in by an approved, su detection system a automatic sprinkler 18.2.2.2.4, 19.2.2.2 This STANDARD Egress Doors Doors in a required equipped with a lat use of a tool or key using one of the fo arrangements: CLINICAL NEEDS LOCKING Where special lock clinical security nee only one locking de each door and pro- rapid removal of oc locks; keying of all at all times; or othe available to the sta 18.2.2.2.5.1, 18.2.2 SPECIAL NEEDS	pproved, supervised automatic m or an approved, supervised system. 2.4 DLLED EGRESS LOCKING Egress Door assemblies ance with 7.2.1.6.2 shall be 2.4 Y EXIT ACCESS LOCKING access door locking in 2.1.6.3 shall be permitted on buildings protected throughout apervised automatic fire and an approved, supervised system. 2.4 is not met as evidenced by: d means of egress shall not be ch or a lock that requires the y from the egress side unless llowing special locking OR SECURITY THREAT king arrangements for the eds of the patient are used, evice shall be made for the coupants by: remote control of locks or keys carried by staff er such reliable means	K 22	The plastic squeeze device that the exit door E-100 has been ren from the door knob. This device was removed on 9/1 The Environmental Supervisor, I VonHoltum will be responsible for correction and monitoring to prev reoccurrence of this deficiency.	noved 2/17. Dean r the	

<b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>	OMB NO. 0938-0391				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X	X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY BUILDING 01 - MAIN BUILDING 01 (X3) COMPLETED				
<b>245395</b> B.	. WING 08/16/2017				
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE				
CROSSROADS CARE CENTER	965 MCMILLAN STREET WORTHINGTON, MN 56187				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE				
K 222 Continued From page 4 safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.4. This deficient practice could affect 42 out of 42	Κ 222				

Facility ID: 00407

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		AND HUMAN SERVICES & MEDICAID SERVICES			INTED: 09/20/2017 FORM APPROVED IB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245395	B, WING		08/16/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CROSSR	OADS CARE CENTE	R		965 MCMILLAN STREET WORTHINGTON, MN 56187	
(X4) ID PREFIX T <b>A</b> G	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
K 222	Continued From pa residents. FINDINGS INCLUE		K 2	22	
	on 08/16/2017, the with a plastic squee Placement of this d	veen 8:00 AM and 12:00 PM Exit door E-100 was observed eze device on the door knob. evice on an egress door s to open the exit door.			
K 353 SS=E	Maintenance Direct	ice was verified by the Facility tor. r System - Maintenance and	К 3	53	9/20/17
	Automatic sprinkler inspected, tested, a with NFPA 25, Stan Testing, and Mainta Protection Systems maintenance, inspe- maintained in a sec available.	Maintenance and Testing and standpipe systems are and maintained in accordance dard for the Inspection, aining of Water-based Fire a. Records of system design, action and testing are cure location and readily system last checked			
	b) Who provided s				
	any non-required of system. 9.7.5, 9.7.7, 9.7.8, a This STANDARD i Based on observat failed to maintain th	KS information on coverage for r partial automatic sprinkler and NFPA 25 s not met as evidenced by: tion and interview, the Facility ne automatic sprinkler system 9.7.5, 9.7.7, 9.7.8, and NFPA		The Environmental Supervisor will over the duties of making sure the sprinkler system is tested on a quar	

Event ID: R7NS21

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CENTERS FOR MEDICARE & MEDICAID SERVICES           ATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           ID PLAN OF CORRECTION         (X1) IDENTIFICATION NUMBER:           245395         245395		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		B. WING			08/16/2017		
NAME OF PROVIDER OR SUPPLIER CROSSROADS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP C 965 MCMILLAN STREET WORTHINGTON, MN 56187	ODE	DE	
(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 COL (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE	
K 353	42 residents. Sprinkler System - Automatic sprinkle inspected, tested, a with NFPA 25, Star Testing, and Mainta Protection Systems maintenance, inspe- maintained in a sec available. a) Date sprinkler b) Who provided c) Water system s Provide in REMAR for any non-require system. 9.7.5, 9.7.7, 9.7.8, FINDINGS INCLUI On facility tour betwo on 8/16/2017, obse documentation cout that the quarterly fil occurred during the	Maintenance and Testing r and standpipe systems are and maintained in accordance hdard for the Inspection, aining of Water-based Fire s. Records of system design, ection and testing are cure location and readily system last checked system test supply source KS information on coverage ed or partial automatic sprinkler and NFPA 25 DE: ween 8:00 AM and 12:00 PM ervation revealed that uld not be located to indicate ire sprinkler inspection e 1st and 2nd quarters of 2017. tice was verified by the Facility	K 35	<ul> <li>basis. Midwestern Mechan conducts a semi-annual test test of the sprinkler system.</li> <li>The next completion date for maintenance of the sprinkle be October 2017.</li> <li>Documentation from Midwe Mechanical, Inc. shows that maintenance and testing of system on 1/26/17 and 7/17.</li> <li>The Environmental Supervit VonHoltum will be responsite correction and monitoring to reoccurrence of deficiency.</li> </ul>	estern they did the sprinkler 7/17. sor, Dean ble for the o prevent a		

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If continuation sheet Page 7 of 7