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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: R7NS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00407

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245395**

2. STATE VENDOR OR MEDICAID NO. (L2) **146319500**

3. NAME AND ADDRESS OF FACILITY
(L3) **CROSSROADS CARE CENTER**
(L4) **965 MCMILLAN STREET**
(L5) **WORTHINGTON, MN** (L6) **56187**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **10/26/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Wendy Buckholz, HFE NE II 11/14/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 11/14/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **01/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the 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,

Kamala 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: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

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:

• 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,

Kamala 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: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

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: 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,

Kamala 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: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: R7NS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00407

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245395**

2. STATE VENDOR OR MEDICAID NO. (L2) **146319500**

3. NAME AND ADDRESS OF FACILITY
(L3) **CROSSROADS CARE CENTER**
(L4) **965 MCMILLAN STREET**
(L5) **WORTHINGTON, MN** (L6) **56187**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **08/17/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Sandra Tatro, HFE NE II 09/23/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 10/25/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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.

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

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

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

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

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

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

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: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING _____ B. WING _____	08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSROADS CARE CENTER	965 MCMILLAN STREET WORTHINGTON, MN 56187

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard survey was completed at your facility 8/14, 8/15, 8/16, and 8/17/17 by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an assessment had been completed for safe self-administration of medication (SAM) for 1 of 2 residents (R46) observed self-administering a nebulizer medication. Findings include:	F 176	Resident 46 has had a self-administration of Medications (SAM). Any other resident affected by this deficient practice had had a Self-Administration of medications (SAM) done for them.	9/20/17

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

Electronically Signed | 09/13/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING _____ B. WING _____	08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSROADS CARE CENTER	965 MCMILLAN STREET WORTHINGTON, MN 56187

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	Continued From page 1 R46's annual Minimum Data Set (MDS) assessment dated 6/14/17, indicated a brief interview for mental status (BIMS) score of 12, The activities of daily living assessment identified all activities as extensive assistance (bed mobility, transfer, walk in room and corridor, locomotion on and off unit, dressing, toilet use and personal hygiene) with the exception of eating which was coded independent. R46's current physician orders included Pulmicort Suspension 0.5 milligrams (mg) per 2 milliliters (ml); inhale orally two times a day related to idiopathic pulmonary fibrosis (scar tissue in the lungs that causes progressive damage). Additionally, R46 also received an as needed order for DuoNeb Solution 0.5-2.5; 3 mg per 3 ml, to be given for shortness of breath, the medication administration record indicated this medication had been administered three times since 7/1/17. On 8/16/17, at 8:03 a.m. RN-B was observed to enter R46's room to administer a nebulizer treatment. RN-B filled the nebulizer with the medication, and handed R46 the mask. RN-B then stated to the surveyor that she starts the nebulizer and the resident will then be responsible to keep the mask on independently. R46 was observed to hold the mask up to his face while the nebulizer treatment began. RN-B left the room to continue with the medication pass. Several minutes later the RN-B returned to the room to remove the nebulizer mask and treatment. At that time, R46 still had the mask up to his face, which he removed when the nurse arrived. R46 was here to state that he thought the treatment was finished. RN-B verified the	F 176	Facility nurses have been trained on the new program explained below as well as on the new policy for performing Self-Administration of Medications (SAM) for residents. The policy for doing Self-Administration of medications (SAM) for residents has been updated to include doing a SAM for residents upon admission and at any other time that it seems appropriate. The Director of Nursing or her designee will review each admission after it has been completed to ensure that the SAM has been completed or else notation made by the admitting nurse that a SAM is not appropriate. Additionally, at any other time, where it appears a resident is able to self-administer medications, the DON will be notified and she, or her designee, will ensure that the SAM is completed by nursing. The DON will appoint someone from the nursing management staff to ensure that SAMs are being done as required upon admission where appropriate or else documented that the SAM is not appropriate. As well, the auditor will audit to determine if any other residents were deemed capable of self-administration of medications and that a SAM was done. These audits will be performed weekly x 4 and then monthly thereafter. The DON will report monthly to the QA Committee on this program.	

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treatment was complete by examining the nebulizer chamber, she then rinsed the chamber and left the mask and chamber to air dry on paper towels.

R46's self-administration assessment dated 6/7/17, indicated R46 did not have the cognitive or functional ability to self-administer his medications.

In an interview with the MDS Coordinator on 8/16/17, at 2:45 p.m. she stated R46 had been in and out of the facility due to being "unable to succeed at home". The MDS Coordinator stated she had completed the initial brief assessment for self-administration of medications following the resident's readmission to the facility. She said the SAM assessment had been conducted to determine whether R46 wished to self-administer medications and to determine whether he had the cognitive ability to perform the task. The MDS Coordinator further stated she could not recall having done any further assessment of R46's ability to conduct self-administration of medications since 6/7/17.

The director of nursing stated during interview on 8/17/17, at 9:45 a.m. that another SAM assessment should have been conducted prior to R46 being allowed to self administer the nebulizer treatment.

The facility's policy titled Self-Administration of Medications, indicated residents of the facility may self-administer their medications if it was determined they were capable of doing so. "As part of their overall evaluation, the staff and practitioner will assess the resident's mental and physical abilities, to determine whether a resident

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F 176	Continued From page 3 is capable of self-administering medications."	F 176		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs.	F 280		9/20/17

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F 280	Continued From page 4 (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary	F 280		

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F 280	Continued From page 5 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care to identify the need for assistive devices for repositioning/transferring from bed for 1 of 3 residents (R37) reviewed for accidents and who used quarter side rails. Findings include: R37 was observed on 8/16/17, at 11:34 a.m. laying in bed with 1/4 side rails bilaterally on the bed in the up position. On 8/16/17, at 3:19 p.m. R37's side rail was observed in the up position. The director of nursing (DON) looked at the rail with the surveyor. It was noted the quarter rail on the door 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 side rail assessment. R37's annual Minimum Data Set (MDS) dated 6/12/17, indicated R37 was rarely understood, had short and long term memory problems, and had moderately impaired decision making. This MDS also indicated R37 had inattention and disorganized thinking, but experienced no	F 280	Care plans regarding side rails have been reviewed and updated for resident 37. Any other resident affected by this deficient practice, including primarily those residents with side rails, have had their care plans reviewed and updated as necessary. Nursing staff and the IDT will be in-serviced on the necessity of updating resident care plans in accordance with changes and use of their side rails. They have also been trained on the policy change and the new practice stated below. The facility policy for side rails has been updated to include updating any resident care plan for the use and purpose of side rails contemporary with the use of them. Additionally, the IDT will review residents with side rails monthly to ensure that any changes in the use of side rails has been care planned. The DON or her designee will review care plans for residents with side rails monthly x3 to ensure compliance with the updated policy stated above after which the IDT will take-over that audit function. The DON will report monthly to the QA Committee on this program.	

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F 280	Continued From page 6 behaviors and no rejection of cares. The MDS indicated R37 required limited assistance of staff for locomotion on unit. The corresponding Care Area Assessment (CAA) dated 6/12/17, indicated R37 had advanced dementia and needed staff assistance with activities of daily living. The CAA also indicated R37 usually had a steady gait but at times needed staff assistance due to unsteadiness. R37's careplan dated 7/1/16, indicated R37 was able to transfer independently with supervision and stand by or limited assist. The careplan also indicated R37 was able to reposition herself in bed. However, the careplan did not include the use of a quarter (1/4) side rail. During an interview with nursing assistant (NA)-B on 8/16/17, at 1:53 p.m., NA-B verified R37 required staff assistance to walk. NA-B stated R37 had dementia but self transferred and utilized the quarter side rail to get out of bed. The facility's undated policy regarding Comprehensive Care Plans indicated, "An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident... f. Identify the professional services that are responsible for each element of care; ... i. Reflect currently recognized standards of practice for problem areas and conditions... 8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change..."	F 280		
F 282 SS=E	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		9/20/17

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F 282	Continued From page 7 (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to 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. Findings include: R24's care plan dated 7/5/17, indicated R24's use of psychotropic medications as a focus. Interventions included monitoring for adverse reaction of psychotropic medications including Tardive Dyskinesia. R24 was admitted to facility on 6/14/17. R24's medical diagnosis included dementia and depression. R24's quarterly Minimum Data Set (MDS) assessment dated 6/21/17, identified a Brief Interview for Mental Status (BIMS) score of 4 indicating severely impaired cognition. R24's current medication summary indicated an order for Risperidol (antipsychotic medication) 0.25 milligrams (mg) by mouth at bedtime for unspecified psychosis; initiated on 6/14/17. Review of R24's medication administration record	F 282	Residents R14, 21, 24, and 30 have been evaluated by a physician for side-effects associated with Tardive Dyskinesia. R21 has also been evaluated by a physician for side effects associated with their antidepressant medication. These residents have been included in the program below for on-going side effect monitoring. Any other resident potentially affected by this deficient practice has been evaluated by a physician for possible side effect of their medications (medications for TD and Antidepressants). Nursing staff will be in-serviced on the importance of evaluating residents taking medications for TD or antidepressants for side effects in accordance with the new program and policy below. The facility has updated their medications administration policy to include assessing residents routinely who take TD or antidepressant medication for side effects. Accordingly, the facility will add the potential side effects to be monitored	

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F 282	Continued From page 8 (MAR) from July 2017 to August 2017, indicated R24 was taking Risperidol daily. 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. 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. R21 was admitted to facility on 5/28/15. R21's medical diagnosis included major depression. R21's quarterly MDS assessment dated 8/1/17, identified a BIMS score of 8 indicating moderately impaired cognition. 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. R21's chart did not reveal a DISCUS had been completed to monitor the side effects of the Haloperidol. R21's chart did not reveal side effect	F 282	to the MAR, next to the medications, so the nurse can easily review for potential side effects of those medications during med pass. The DON or her designee will audit weekly x4 and then monthly thereafter to ensure that nurses are using this side effect monitoring program. The audit will include a review of (10) residents receiving either TD or antidepressant medications. The DON will report monthly to the QA Committee on this program.	

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monitoring documented for Sertaline following medication increase.

During interview on 8/16/17, at 2:31 p.m. the director of nursing (DON) stated she did not see orders for side effect monitoring or documentation in R21's chart. The next day on 8/17/17, at 8:08 a.m. the DON stated a baseline DISCUS assessment should be done upon admission, starting a new antipsychotic medication, when there was a significant change or every 6 months. Later that day at 11:10 a.m., the DON verified no DISCUS assessment had been completed since R24 had been admitted to facility. The DON was not able to find any documentation that a DISCUS had been completed on R21.
R14 was admitted on 4/10/08, and the Physician Order Report dated 8/17/17, directed staff to administer Celexa 10 mg by mouth (PO) daily for depression/mood; initiation on 8/1/17, and Risperidone 2 mg, PO at bed time for delusional related to other schizophrenia.

The Care Area Assessment (CAA) dated 2/5/17, identified R14 with diagnoses of "schizophrenia, depression and psychosis" which required psychotropic medications prescribed by the primary care provider. It also indicated R14 was at risk for Tardive Dyskinesia.

The care plan dated 5/5/17, indicated R14 had used psychotropic medications to manage behaviors of "depression, schizophrenia, psychosis". Staff were directed to administer antipsychotic medication as ordered by physician and to monitor side effect and effectiveness of medication every shift. The care plan dated 4/28/17, also indicated R14 had major depressive

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disorder and staff were directed to administer medication as ordered and to monitor and document the side effect and effectiveness of the medication; however, the facility lack documentation Risperidone and Celexa were adequately monitored.

On 8/16/17, at 8:20 a.m. registered nurse (RN)-D stated they do not have a side effect monitoring system; stating, "we will put the side effect monitoring and behavior monitoring as soon as possible".
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.

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.

The physician orders 8/1/17, indicated R30 was 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.

R30's careplan dated 12/13/16, indicated: Monitor

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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 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. No behaviors were exhibited.

At 2:13 p.m. medical records verified the 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 did not have many behaviors but might get anxious once in a while.

On 8/17/17, at 8:32 a.m. the 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 1:27 p.m. DON stated she expected staff to follow residents' care plans.

An undated policy provided by the facility Antipsychotic Medication Use, indicated: " ... 14.

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F 282	Continued From page 12 Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the Attending Physician: ... tardive dyskinesia ..." Undated policy provided by the facility Care Plans -- Comprehensive indicated, "An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident... f. Identify the professional services that are responsible for each element of care; ... i. Reflect currently recognized standards of practice for problem areas and conditions...."	F 282		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with	F 323		9/20/17

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F 323	Continued From page 13 the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT 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 randomly reviewed (R9, R27, R38, R42) for potential environmental hazards. Findings include: R37 was observed on 8/16/17, at 11:34 a.m. laying in bed with 1/4 side rails bilaterally on the bed in the up position. On 8/16/17, at 3:19 p.m. R37's side rail was observed in the up position. The director of nursing (DON) looked at the rail with the surveyor. It was noted the quarter rail on the door 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 side rail assessment. R37's annual Minimum Data Set (MDS) dated 6/12/17, indicated R37 was rarely understood, had short and long term memory problems, and	F 323	Residents R37, R18 have had their side rails adjusted to meet the officials standards. Also, R9, 27, 38, 42 have had their bed rails adjusted so they are safe and meet industry standards. Residents with side rails throughout the facility have had their side rails reviewed; if any problems are found so that the side rails are not ill-fitting or not safe, corrections have been made. Nursing staff will be in-serviced on the proper standards for side rails as assistive devices and on the program explained below. The policy for side rail use has been updated. A new program of side rail removal has been instituted so that side rails will be removed where possible and other safety measures instituted. Where side rails exist, a program of ensuring safety has been instituted which consists of checking the side rails routinely to ensure that they meet the standards required in the industry. This review occurs monthly and is documented so that any corrections made to side rails can be tracked. An audit will be done by facility	

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F 323	Continued From page 14 had moderately impaired decision making. This MDS also indicated R37 had inattention and disorganized thinking, but experienced no behaviors and no rejection of cares. The MDS indicated R37 required limited assistance of staff for locomotion on unit. The corresponding Care Area Assessment (CAA) dated 6/12/17, indicated R37 had advanced dementia and needed staff assistance with activities of daily living. The CAA also indicated R37 usually had a steady gait but at times needed staff assistance due to unsteadiness. R37's careplan dated 7/1/16, indicated R37 was able to transfer independently with supervision and stand by or limited assist. The careplan also indicated R37 was able to reposition herself in bed. However, the careplan did not include the use of a quarter (1/4) side rail. During an interview with nursing assistant (NA)-B on 8/16/17 at 1:53 p.m., NA-B verified R37 required staff assistance to walk. NA-B stated R37 had dementia but self transferred and utilized the quarter side rail to get out of bed. On 8/16/17, at 2:24 p.m. NA-A stated R37 needed stand by assist for walking and was steady on her feet. NA-A also stated R37 used her side rails to pull herself up from bed. NA-A further stated if a resident's side rails moved more than a little she would call the maintenance to fix. On 8/16/17, at 2:26 p.m. registered nurse (RN)-C stated nurses did not complete the side rail assessments but that the MDS Coordinator and the assistant DON (ADON) completed the side rail assessments. At 2:31 p.m. the MDS	F 323	maintenance or their designee each month based on (10) residents with side rails selected by the facility Administrator (ED) at random. The basis of the audit will be to ensure that side rails are being kept safe and within the standards in the industry. Maintenance will report monthly to the QA Committee on this program.	

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Coordinator stated when she completed the side rail assessments she would ask the resident whether they wanted the rail, and that she would complete the side rail assessments quarterly. The MDS Coordinator further explained that she physically checked the side rails when she completed an assessment to make sure they were safe, and that there were no gaps between the rail and the bed. The MDS Coordinator stated when a side rail was loose she would call maintenance to tighten or replace the rail. The MDS Coordinator verified R37's most recent side rail assessment was dated 6/23/16.

On 8/16/17, at 2:51 p.m. the DON stated her expectation was that side rails would be physically checked when assessed to ensure they were safe. The DON also stated would follow standard practice protocol.

On 8/17/17, at 8:22 a.m. the DON stated too much movement in a side rail could cause balance problems for a resident attempting to hold on to it when getting up.

On 8/17/17, at 9:07 a.m. the ADON stated she completed side rail assessments upon admission, quarterly, at the time of a significant change, and when there were mobility changes. However, the ADON stated she did not physically check the side rails for safety because it was not identified on the form.

On 8/17/17, at 10:02 a.m. RN-B stated R37 gets herself in and out of bed herself.
R18's admission MDS dated 7/18/17, indicated R18's cognition was severely impaired and that R18 needed staff assist with transfers and bed mobility. R18's CAA dated 7/18/17, indicated R18

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had a balance deficit related to compression fracture and needed limited to extensive assist with transfers, toileting and ambulation. It was also indicated R18 was at risk for falls with serious injury.

R18's care plan dated 7/28/17, indicated R18 used grab bars to maximize independence with turning and repositioning in bed, and was able to transfer with supervision using four wheeled walkers.

During an initial observation on 8/14/17, at 7:21 p.m. R18's 1/4 side rail was noted not to fit properly. The rail was noted to move from the bed outward about two inches. At the time of the observation, R18 stated to the surveyor, "That is one thing I want them to fix."

On 8/16/17, at 7:04 a.m. R18 was observed to be laying in bed with 1/4 side rail up on the door side.

On 8/17/17, at 8:21 a.m. the surveyor and the DON went to R18's room to look at the 1/4 side rail. The DON verified the 1/4 side rail was loose. She stated, "What concerns me most is the movement back and forth". The DON stated there was excessive motion of the side rail and that it was not stable.

Other observations of siderails revealed the following side rails that were not securely attached to the bed:

R42's 1/4 side rail on the door side was observed in the up position on 8/14/17, at 7:11 p.m. The rail was observed to move from the mattress outward about 2-3 inches.

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F 323	Continued From page 17 R38's 1/4 side rail on the door side was observed in the up position on 8/15/17, at 9:56 a.m. The rail was observed to move from the mattress outward about 3-4 inches. R27's 1/4 side rail on the door side was observed in the up position on 8/15/17, at 9:59 a.m. The rail was observed to move from the mattress outward about 3-4 inches. R9's 1/4 side rail on the door side of the bed was observed in up position on 8/15/17, at 3:57 p.m. The rail was observed to move from the mattress outward about 3-4 inches.	F 323		
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 329		9/20/17

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F 329	Continued From page 18 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure psychoactive medications were monitored for side effects and/or adverse effects, and/or failed to follow-up with the consulting pharmacist (CP) recommendations for 4 of 5 residents (R24, R21, R14, R30) reviewed for unnecessary medications. Findings include: R24 was admitted on 6/14/17, and had medical diagnoses (dx) including dementia and depression. R24's quarterly Minimum Data Set (MDS) assessment dated 6/21/17, identified a Brief Interview for Mental Status (BIMS) score of 4, indicating the resident had severely impaired cognition. R24's current medication summary indicated a physician order for Risperidol (antipsychotic	F 329	R 14, 21, 24, 30 had their psychoactive medications reviewed including side effects and effectiveness by a physician. Any other resident for whom psychoactive medications are prescribed has been reviewed for effectiveness and side effects and changes made where necessary. Consulting pharmacist recommendations have been reviewed going back (30) days to ensure they have been properly processed and any missed have been managed as required. Nurses will be trained on the importance of monitoring side effects and effectiveness of psychoactive medications for their residents as indicated by the program described below. Additionally, nursing management and nursing staff will be in-serviced by the DON on the	

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F 329	Continued From page 19 medication) 0.25 milligrams (mg) by mouth at bedtime for unspecified psychosis; initiated on 6/14/17. Review of R24's medication administration record (MAR) from July 2017 through August 2017, indicated R24 was taking Risperidol daily. 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 medications (Dyskinesia Identification System: Condensed User Scale (DISCUS) R21 was admitted to facility on 5/28/15. R21's medical diagnosis included major depression. R21's quarterly MDS assessment dated 8/1/17, identified a BIMS score of 8 indicating moderately impaired cognition. R21's current medication summary indicated an order for Haloperidol (antipsychotic medication) 0.25 mg orally daily for depression/mood; initiated on 6/21/16. Review of R21's MAR from July 2017 through August 2017, indicated Risperidol was administered daily as ordered. The current medication summary also identified 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 MAR from July 2017 to August 2017 indicated both medications were given as ordered. R21's chart lacked a DISCUS assessment, to monitor the side effects of the Haloperidol. R21's chart did not reveal side effect monitoring	F 329	importance of following through with consultant pharmacist recommendations. The facility policy for psychoactive medications has been updated to include monitoring for side effects routinely (with each administration) and for effectiveness. Side effect monitoring and effectiveness of psychoactive medications will be added to the resident MARs for all residents who are prescribed psychoactive medications. As for consultant pharmacist recommendations, a copy will be made of each pharmacist recommendation and checked off by the DON or her designee once completed (completion means processed through to the physician or DON and completed and "check-off" means a check mark and initial placed in the upper right hand corner of each recommendation when completed) and them the copy will be compared against the original. At the end of each month, the DON or designee reviews all pharmacy consultant recommendations to ensure they are completed. If any are not completed, the DON addresses them and ensures completion. These completed copies of pharmacy recommendations go into a monthly file and are kept for (12) months. The DON will monitor weekly x4 and then monthly thereafter (10) residents each time who are on psychoactive medications to ensure that nurses are properly monitoring side effects and	

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F 329	Continued From page 20 documented for Sertaline following medication increase. A pharmacy note from consulting pharmacist (CP)-B dated 12/2/16, indicated a DISCUS assessment was not available in the chart. Subsequent pharmacy notes from CP-A and CP-B did not address lack of DISCUS assessment. Pharmacy notes from 12/2/16, did not address lack of side effect monitoring for Sertaline. 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. On 8/17/17, at 8:08 a.m. the DON stated a baseline DISCUS assessment should be done upon admission, upon initiation of a newly prescribed antipsychotic medication, a significant change and/or every 6 months. Later that day at 11:10 a.m., the DON verified no DISCUS assessment had been completed since R24 since admission and was unable to locate documentation to confirm a DISCUS had been completed for R21. Review of the undated facility policy Antipsychotic Medication Use indicated the nursing staff would monitor for side effects including tardive dyskinesia (TD) . R14 was admitted on 4/10/08, and the Physician Order Report dated 8/17/17, directed staff to administer Celexa 10 mg by mouth (PO) daily for depression/mood; initiation on 8/1/17, and Risperidone 2 mg, PO at bed time for delusional related to other schizophrenia.	F 329	effectiveness of their psychoactive medications. The DON will report monthly to the QA Committee on this program. The pharmacy consultant recommendations are audited by the facility ED or his designee: the facility ED will look for the check-mark and initial of the DON or her designee in the upper right hand corner of each copy of the monthly pharmacy consultant recommendation to ensure it has been properly processed. If no check mar or initial exists, the ED will bring it to the attention of the DON for processing.	

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F 329	Continued From page 21 The Care Area Assessment (CAA) dated 2/5/17, identified R14 with diagnoses of "schizophrenia, depression and psychosis" which required psychotropic medications prescribed by the primary care provider. It also indicated R14 was at risk for Tardive Dyskinesia. The Review of consultant pharmacist's medication regimen dated 4/3/17, stated R14 "takes citalopram 10 mg daily." According to this record, the medication was due per state and federal law to evaluate the potential dose reduction. The CP also stated R14 has "minimal to no depression and may no longer require treatment". However, the facility did not follow through the CP's recommendation. Pharmacy consultant note dated 3/7/17, revealed resident was on Benztropine for a long period of time. "please assess if you are still desired benefit of this medication for [R14] OR if a DC [discontinue] is appropriate". However, the facility did not follow through the CP's recommendation. Care plan dated 5/5/17, indicated R14 had been used psychotropic medication to manage behaviors of "depression, schizophrenia, psychosis". Staff were directed to administer antipsychotic medication as ordered by physician and to monitor side effect and effectiveness of medication every shift. The care plan dated 4/28/17, also indicated R14 had major depressive disorder and staff were directed to administer medication as ordered and to monitor and document the side effect and effectiveness of the medication; however, the facility lack documentation Risperidone and Celexa were adequately monitored.	F 329		

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F 329	Continued From page 22 On 8/16/17, at 8:20 a.m. registered nurse (RN)-D stated they do not have a side effect monitoring system; stating, "we will put the side effect monitoring and behavior monitoring as soon as possible". 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." Furthermore, the DON admitted they did not have system in place to monitor side effect for psychoactive medication and stated, "I do accept that." 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. 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. The physician orders 8/1/17, indicated R30 was	F 329		

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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.

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 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. No behaviors were exhibited.

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 did not have many behaviors but might get anxious once in a while.

On 8/17/17, at 8:32 a.m. the 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

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F 329	Continued From page 24 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 review and had not made a recommendation for a DISCUS to be completed for R30. CP-A stated he did not believe he had given any recommendation for any resident at the facility to have TD monitoring completed. On 8/17/17, at 1:27 p.m. DON stated she expected staff to follow residents' care plans. An undated policy provided by the facility Antipsychotic Medication Use indicated, " ... 14. Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the Attending Physician: ... tardive dyskinesia ..." An undated facility policy "Psychotropic Medication Use" indicated, "All psychotropic medications will be used within the dosage guidelines listed... Or clinical justification will be documented for dosages that exceed the listed guidelines for more than 48 hours."	F 329		
F 428 SS=E	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not	F 428		9/20/17

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limited to, drugs in the following categories:

(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic.

(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.

(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.

(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.

(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING _____ B. WING _____	08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSROADS CARE CENTER	965 MCMILLAN STREET WORTHINGTON, MN 56187

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 26 to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure pharmacy recommendations were identified, and or followed through with for 4 of 5 residents reviewed (R24, R21, R14 and R30) who utilized psycho active medications. Findings include: R24 was admitted on 6/14/17, and had medical diagnoses (dx) including dementia and depression. R24's quarterly Minimum Data Set (MDS) assessment dated 6/21/17, identified a Brief Interview for Mental Status (BIMS) score of 4, indicating the resident had severely impaired cognition. R24's current medication summary indicated a physician order for Risperidol (antipsychotic medication) 0.25 milligrams (mg) by mouth at bedtime for unspecified psychosis; initiated on 6/14/17. Review of R24's medication administration record (MAR) from July 2017 through August 2017, indicated R24 was taking Risperidol daily. 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 medications (Dyskinesia Identification System: Condensed User Scale (DISCUS). There was no Consultant Pharmacist (CP)recommendation related to this oversight.	F 428	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. 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	

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F 428	Continued From page 27 R21 was admitted to facility on 5/28/15. R21's medical diagnosis included major depression. R21's quarterly MDS assessment dated 8/1/17, identified a BIMS score of 8 indicating moderately impaired cognition. R21's current medication summary indicated an order for Haloperidol (antipsychotic medication) 0.25 mg orally daily for depression/mood; initiated on 6/21/16. Review of R21's MAR from July 2017 through August 2017, indicated Risperidol was administered daily as ordered. The current medication summary also identified 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 MAR from July 2017 to August 2017 indicated both medications were given as ordered. R21's chart lacked a DISCUS assessment, to monitor the side effects of the Haloperidol. R21's chart did not reveal side effect monitoring documented for Sertaline following medication increase. A pharmacy note from CP-B dated 12/2/16, indicated a DISCUS assessment was not available in the chart. Subsequent pharmacy notes from CP-A and CP-B did not address lack of DISCUS assessment. Pharmacy notes from 12/2/16, did not address lack of side effect monitoring for Sertaline. 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	F 428	unreturned pharmacy recommendations at time of monthly review before exiting the building. DON or nurse designee will follow-up on non-response. DON or designee will audit compliance with plan of correction monthly followed by review in Quarterly QA meeting. Compliance/effectiveness of plan will be reviewed per Quality Assurance Team next scheduled meeting.	

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R21's chart.

On 8/17/17, at 8:08 a.m. the DON stated a baseline DISCUS assessment should be done upon admission, upon initiation of a newly prescribed antipsychotic medication, a significant change and/or every 6 months. Later that day at 11:10 a.m., the DON verified no DISCUS assessment had been completed since R24 since admission and was unable to locate documentation to confirm a DISCUS had been completed for R21.

During interview on 8/17/17, at 10:38 a.m. CP-A stated he generally recommended quarterly DISCUS be conducted to watch for TD (Tardive Diskynesia). CP-A stated he had only filled in for CP-B during August, but that CP-B usually conducted the pharmacy reviews for this facility. CP-A stated he would have CP-B call back, but no call was returned.

R14 was admitted to facility on 4/10/08. R14's Physician Order Report dated 8/17/17, directed staff to administer Celexa 10 mg by mouth (PO) daily for depression/mood with a start date of 8/1/17, and Risperidone 2 mg, PO at bed time for delusional related to other schizophrenia

R14's Care Area Assessment (CAA) 2/5/17, identified diagnoses of "schizophrenia, depression and psychosis" which required psychotropic medications prescribed by the primary care provider. It also indicated R14 was at risk for Tardive Dyskinesia.

The Review of consultant pharmacist's medication regimen dated 4/3/17, stated R14 "takes citalopram 10 mg daily." According to this

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record, the medication was due per state and federal law to evaluate the potential dose reduction. The CP also stated R14 has "minimal to no depression and may no longer require treatment". However, the CP did not follow through whether the physician had acted upon the recommendations pharmacist was made to the facility.

A pharmacy consultant note titled "Note to Attending Physician/Prescriber" dated 3/7/17, revealed the resident was on Benztropine for a long period of time and indicated: "please assess if you still desire benefit of this medication for [R14] OR if a DC [discontinue] is appropriate". However, the there was no follow through to determine whether the physician had acted upon the recommendation the pharmacist made to the facility.

On 8/16/17, at 9:42 a.m. the DON indicated the facility had a system in place to assure the pharmacist's recommendations were followed through. However, she acknowledged this had been missed for R14 and stated the resident care coordinator should have given the recommendation to the physician for review. The DON added, "The same issue occurred when the March and April [recommendations] were not addressed." Furthermore, the DON admitted they did not have system in place to monitor side effect for psychoactive medication.

On 8/17/17, at 10:55 a.m. a call was placed to Avera Long- Term pharmacy to reach CP-B who had given recommendations related to R14's medications. However, CP-B was unavailable. The surveyor gave email address to CP-A, and with questions surveyor had in order to get

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explanation why the recommendations were not followed through. No email was received from CP-B.

R30 was admitted to the facility on 11/23/14. R30's quarterly MDS dated 5/19/17, included a Dx of Non-Alzheimer's Dementia and Depression, and indicated R30 was taking 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 with no rejection of cares.

R30's CAA dated 11/23/16, indicated R30 was on antidepressants and an antipsychotic medication for depression, delirium Dx and to help with anxiety and her behaviors/mood. The CAA also indicated R30 was at risk for psychotropic drug side effects.

R30's physician orders 8/1/17, indicated R30 was 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.

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.

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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, 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. assistant DON (ADON) stated she completed DISCUS on admission for baseline and 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 review and had not made a recommendation for a DISCUS to be completed for R30. CP-A stated he did not believe he had given any recommendation for any resident at the facility to have TD monitoring completed.

On 8/17/17, at 1:27 p.m. DON stated she expected staff to follow residents' careplans.

Review of CP-A's documentation dated 8/1/17, and CP-B's documentation dated 7/3/17, indicated no recommendation for side effects and/or TD monitoring was made.

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F 428	Continued From page 32 Review of the undated facility policy Antipsychotic Medication Use, indicated the nursing staff would monitor for side effects including tardive dyskinesia (TD) ." ... 14. Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the Attending Physician: ... tardive dyskinesia ..." Review of the undated Consultant Pharmacist policy, indicated the consultant pharmacist must supply a written report of any irregularities found to the attending physician including psychoactive assessment and monitoring to meet the needs of the resident." ... 2. The consultant pharmacist must supply a written report of any irregularities found to the attending physician, the facility's medical director and the director of nursing within 5 working days of exits. These reports must be acted upon... 4. The reports shall be acted upon within 35 days of receipt... 6. Any irregularity not addressed by the attending physician (after 3 attempts) within the 35 day time frame will be forwarded to the medical director for action..." In addition, a Policy provided by the facility dated 6/15, Consultant Pharmacist Services Provider Requirements indicated, " ... F. Specific activities that the consultant pharmacist performs includes, but is not limited to: ... 2) Communicating to the responsible prescriber and the facility leadership ... including recommendations for changes in medication therapy and monitoring ..."	F 428		

DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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.

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 Meath

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On August 14, 15, 16 and 17 2017, surveyors of this Department's staff, visited the above provider 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. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: 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. Findings include: R24's care plan dated 7/5/17, indicated R24's use of psychotropic medications as a focus. Interventions included monitoring for adverse reaction of psychotropic medications including Tardive Dyskinesia. R24 was admitted to facility on 6/14/17. R24's medical diagnosis included dementia and depression. R24's quarterly Minimum Data Set (MDS) assessment dated 6/21/17, identified a Brief Interview for Mental Status (BIMS) score of 4 indicating severely impaired cognition.	2 565	Corrected	9/20/17

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2 565	Continued From page 3 R24's current medication summary indicated an order for Risperidol (antipsychotic medication) 0.25 milligrams (mg) by mouth at bedtime for unspecified psychosis; initiated on 6/14/17. Review of R24's medication administration record (MAR) from July 2017 to August 2017, indicated R24 was taking Risperidol daily. 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. 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. R21 was admitted to facility on 5/28/15. R21's medical diagnosis included major depression. R21's quarterly MDS assessment dated 8/1/17, identified a BIMS score of 8 indicating moderately impaired cognition. 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	2 565		

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2 565	Continued From page 4 and Sertaline as ordered. R21's chart did not reveal a DISCUS had been completed to monitor the side effects of the Haloperidol. R21's chart did not reveal side effect monitoring documented for Sertaline following medication increase. During interview on 8/16/17, at 2:31 p.m. the director of nursing (DON) stated she did not see orders for side effect monitoring or documentation in R21's chart. The next day on 8/17/17, at 8:08 a.m. the DON stated a baseline DISCUS assessment should be done upon admission, starting a new antipsychotic medication, when there was a significant change or every 6 months. Later that day at 11:10 a.m., the DON verified no DISCUS assessment had been completed since R24 had been admitted to facility. The DON was not able to find any documentation that a DISCUS had been completed on R21. R14 was admitted on 4/10/08, and the Physician Order Report dated 8/17/17, directed staff to administer Celexa 10 mg by mouth (PO) daily for depression/mood; initiation on 8/1/17, and Risperidone 2 mg, PO at bed time for delusional related to other schizophrenia. The Care Area Assessment (CAA) dated 2/5/17, identified R14 with diagnoses of "schizophrenia, depression and psychosis" which required psychotropic medications prescribed by the primary care provider. It also indicated R14 was at risk for Tardive Dyskinesia. The care plan dated 5/5/17, indicated R14 had used psychotropic medications to manage behaviors of "depression, schizophrenia,	2 565		

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2 565	Continued From page 5	2 565		

psychosis". Staff were directed to administer antipsychotic medication as ordered by physician and to monitor side effect and effectiveness of medication every shift. The care plan dated 4/28/17, also indicated R14 had major depressive disorder and staff were directed to administer medication as ordered and to monitor and document the side effect and effectiveness of the medication; however, the facility lack documentation Risperidone and Celexa were adequately monitored.

On 8/16/17, at 8:20 a.m. registered nurse (RN)-D stated they do not have a side effect monitoring system; stating, "we will put the side effect monitoring and behavior monitoring as soon as possible".

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.

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.

The physician orders 8/1/17, indicated R30 was on antidepressants Remeron 7.5 mg, Zoloft 25 mg and antipsychotic Risperdal 0.25 mg.

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2 565	Continued From page 6 Review of R30's August 2017 MAR indicated R30 was taking Risperdal, Remeron and Zoloft daily. 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 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. No behaviors were exhibited. At 2:13 p.m. medical records verified the 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 did not have many behaviors but might get anxious once in a while. On 8/17/17, at 8:32 a.m. the 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 1:27 p.m. DON stated she	2 565		

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2 565	Continued From page 7 expected staff to follow residents' care plans. An undated policy provided by the facility Antipsychotic Medication Use, indicated: " ... 14. Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the Attending Physician: ... tardive dyskinesia ..." Undated policy provided by the facility Care Plans -- Comprehensive indicated, "An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident... f. Identify the professional services that are responsible for each element of care; ... i. Reflect currently recognized standards of practice for problem areas and conditions...." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. The director of nursing or designee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in	2 570		9/20/17

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2 570	Continued From page 8 disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care to identify the need for assistive devices for repositioning/transferring from bed for 1 of 3 residents (R37) reviewed for accidents and who used quarter side rails. Findings include: R37 was observed on 8/16/17, at 11:34 a.m. laying in bed with 1/4 side rails bilaterally on the bed in the up position. On 8/16/17, at 3:19 p.m. R37's side rail was observed in the up position. The director of nursing (DON) looked at the rail with the surveyor. It was noted the quarter rail on the door 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 side rail assessment. R37's annual Minimum Data Set (MDS) dated	2 570	Corrected	

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2 570	Continued From page 9 6/12/17, indicated R37 was rarely understood, had short and long term memory problems, and had moderately impaired decision making. This MDS also indicated R37 had inattention and disorganized thinking, but experienced no behaviors and no rejection of cares. The MDS indicated R37 required limited assistance of staff for locomotion on unit. The corresponding Care Area Assessment (CAA) dated 6/12/17, indicated R37 had advanced dementia and needed staff assistance with activities of daily living. The CAA also indicated R37 usually had a steady gait but at times needed staff assistance due to unsteadiness. R37's careplan dated 7/1/16, indicated R37 was able to transfer independently with supervision and stand by or limited assist. The careplan also indicated R37 was able to reposition herself in bed. However, the careplan did not include the use of a quarter (1/4) side rail. During an interview with nursing assistant (NA)-B on 8/16/17, at 1:53 p.m., NA-B verified R37 required staff assistance to walk. NA-B stated R37 had dementia but self transferred and utilized the quarter side rail to get out of bed. The facility's undated policy regarding Comprehensive Care Plans indicated, "An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident... f. Identify the professional services that are responsible for each element of care; ... i. Reflect currently recognized standards of practice for problem areas and conditions... 8. Assessments of residents are ongoing and care plans are revised as information about the	2 570		

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2 570	Continued From page 10 resident and the resident's condition change..." SUGGESTED METHOD OF CORRECTION: The DON or designee could review any policies, procedures or facility processes for resident care plan development . Appropriate staff could be educated regarding any changes. The DON or designee could develop a system to monitor the care plan to ensure revisions are completed timely. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 570		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does	21530		9/20/17

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21530	Continued From page 11 not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure pharmacy recommendations were identified, and or followed through with for 4 of 5 residents reviewed (R24, R21, R14 and R30) who utilized psycho active medications. Findings include: R24 was admitted on 6/14/17, and had medical diagnoses (dx) including dementia and depression. R24's quarterly Minimum Data Set (MDS) assessment dated 6/21/17, identified a Brief Interview for Mental Status (BIMS) score of 4, indicating the resident had severely impaired cognition. R24's current medication summary indicated a physician order for Risperidol (antipsychotic medication) 0.25 milligrams (mg) by mouth at bedtime for unspecified psychosis; initiated on	21530	Corrected	

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21530	Continued From page 12 6/14/17. Review of R24's medication administration record (MAR) from July 2017 through August 2017, indicated R24 was taking Risperidol daily. 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 medications (Dyskinesia Identification System: Condensed User Scale (DISCUS). There was no Consultant Pharmacist (CP)recommendation related to this oversight. R21 was admitted to facility on 5/28/15. R21's medical diagnosis included major depression. R21's quarterly MDS assessment dated 8/1/17, identified a BIMS score of 8 indicating moderately impaired cognition. R21's current medication summary indicated an order for Haloperidol (antipsychotic medication) 0.25 mg orally daily for depression/mood; initiated on 6/21/16. Review of R21's MAR from July 2017 through August 2017, indicated Risperidol was administered daily as ordered. The current medication summary also identified 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 MAR from July 2017 to August 2017 indicated both medications were given as ordered. R21's chart lacked a DISCUS assessment, to monitor the side effects of the Haloperidol. R21's chart did not reveal side effect monitoring documented for Sertaline following medication	21530		

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increase.

A pharmacy note from CP-B dated 12/2/16, indicated a DISCUS assessment was not available in the chart. Subsequent pharmacy notes from CP-A and CP-B did not address lack of DISCUS assessment. Pharmacy notes from 12/2/16, did not address lack of side effect monitoring for Sertaline.

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.

On 8/17/17, at 8:08 a.m. the DON stated a baseline DISCUS assessment should be done upon admission, upon initiation of a newly prescribed antipsychotic medication, a significant change and/or every 6 months. Later that day at 11:10 a.m., the DON verified no DISCUS assessment had been completed since R24 since admission and was unable to locate documentation to confirm a DISCUS had been completed for R21.

During interview on 8/17/17, at 10:38 a.m. CP-A stated he generally recommended quarterly DISCUS be conducted to watch for TD (Tardive Diskynesia). CP-A stated he had only filled in for CP-B during August, but that CP-B usually conducted the pharmacy reviews for this facility. CP-A stated he would have CP-B call back, but no call was returned.

R14 was admitted to facility on 4/10/08. R14's Physician Order Report dated 8/17/17, directed staff to administer Celexa 10 mg by mouth (PO) daily for depression/mood with a start date of

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21530	Continued From page 14 8/1/17, and Risperidone 2 mg, PO at bed time for delusional related to other schizophrenia R14's Care Area Assessment (CAA) 2/5/17, identified diagnoses of "schizophrenia, depression and psychosis" which required psychotropic medications prescribed by the primary care provider. It also indicated R14 was at risk for Tardive Dyskinesia. The Review of consultant pharmacist's medication regimen dated 4/3/17, stated R14 "takes citalopram 10 mg daily." According to this record, the medication was due per state and federal law to evaluate the potential dose reduction. The CP also stated R14 has "minimal to no depression and may no longer require treatment". However, the CP did not follow through whether the physician had acted upon the recommendations pharmacist was made to the facility. A pharmacy consultant note titled "Note to Attending Physician/Prescriber" dated 3/7/17, revealed the resident was on Benztropine for a long period of time and indicated: "please assess if you still desire benefit of this medication for [R14] OR if a DC [discontinue] is appropriate". However, the there was no follow through to determine whether the physician had acted upon the recommendation the pharmacist made to the facility. On 8/16/17, at 9:42 a.m. the DON indicated the facility had a system in place to assure the pharmacist's recommendations were followed through. However, she acknowledged this had been missed for R14 and stated the resident care coordinator should have given the recommendation to the physician for review. The	21530		

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21530	Continued From page 15 DON added, "The same issue occurred when the March and April [recommendations] were not addressed." Furthermore, the DON admitted they did not have system in place to monitor side effect for psychoactive medication. On 8/17/17, at 10:55 a.m. a call was placed to Avera Long- Term pharmacy to reach CP-B who had given recommendations related to R14's medications. However, CP-B was unavailable. The surveyor gave email address to CP-A, and with questions surveyor had in order to get explanation why the recommendations were not followed through. No email was received from CP-B. R30 was admitted to the facility on 11/23/14. R30's quarterly MDS dated 5/19/17, included a Dx of Non-Alzheimer's Dementia and Depression, and indicated R30 was taking 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 with no rejection of cares. R30's CAA dated 11/23/16, indicated R30 was on antidepressants and an antipsychotic medication for depression, delirium Dx and to help with anxiety and her behaviors/mood. The CAA also indicated R30 was at risk for psychotropic drug side effects. R30's physician orders 8/1/17, indicated R30 was 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.	21530		

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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.

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, 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. assistant DON (ADON) stated she completed DISCUS on admission for baseline and 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 review and had not made a recommendation for a DISCUS to be completed for R30. CP-A stated he did not believe he had

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given any recommendation for any resident at the facility to have TD monitoring completed.

On 8/17/17, at 1:27 p.m. DON stated she expected staff to follow residents' careplans.

Review of CP-A's documentation dated 8/1/17, and CP-B's documentation dated 7/3/17, indicated no recommendation for side effects and/or TD monitoring was made.

Review of the undated facility policy Antipsychotic Medication Use, indicated the nursing staff would monitor for side effects including tardive dyskinesia (TD) ." ... 14. Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the Attending Physician: ... tardive dyskinesia ..."

Review of the undated Consultant Pharmacist policy, indicated the consultant pharmacist must supply a written report of any irregularities found to the attending physician including psychoactive assessment and monitoring to meet the needs of the resident." ... 2. The consultant pharmacist must supply a written report of any irregularities found to the attending physician, the facility's medical director and the director of nursing within 5 working days of exits. These reports must be acted upon... 4. The reports shall be acted upon within 35 days of receipt... 6. Any irregularity not addressed by the attending physician (after 3 attempts) within the 35 day time frame will be forwarded to the medical director for action..."

In addition, a Policy provided by the facility dated 6/15, Consultant Pharmacist Services Provider Requirements indicated, " ... F. Specific activities that the consultant pharmacist performs includes,

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21530	Continued From page 18 but is not limited to: ... 2) Communicating to the responsible prescriber and the facility leadership ... including recommendations for changes in medication therapy and monitoring ..." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Nursing staff could be educated as necessary to the importance of the pharmacist's review. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance, and could report findings to the facility's quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for	21535		9/20/17

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21535	Continued From page 19 Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure psychoactive medications were monitored for side effects and/or adverse effects, and/or failed to follow-up with the consulting pharmacist (CP) recommendations for 4 of 5 residents (R24, R21, R14, R30) reviewed for unnecessary medications. Findings include: R24 was admitted on 6/14/17, and had medical diagnoses (dx) including dementia and depression. R24's quarterly Minimum Data Set (MDS) assessment dated 6/21/17, identified a Brief Interview for Mental Status (BIMS) score of 4, indicating the resident had severely impaired cognition. R24's current medication summary indicated a physician order for Risperidol (antipsychotic medication) 0.25 milligrams (mg) by mouth at bedtime for unspecified psychosis; initiated on 6/14/17. Review of R24's medication administration record (MAR) from July 2017 through August 2017, indicated R24 was taking Risperidol daily. R24's chart did not reveal a DISCUS had been	21535	Corrected	

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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 medications (Dyskinesia Identification System: Condensed User Scale (DISCUS)

R21 was admitted to facility on 5/28/15. R21's medical diagnosis included major depression. R21's quarterly MDS assessment dated 8/1/17, identified a BIMS score of 8 indicating moderately impaired cognition.

R21's current medication summary indicated an order for Haloperidol (antipsychotic medication) 0.25 mg orally daily for depression/mood; initiated on 6/21/16. Review of R21's MAR from July 2017 through August 2017, indicated Risperidol was administered daily as ordered. The current medication summary also identified 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 MAR from July 2017 to August 2017 indicated both medications were given as ordered.

R21's chart lacked a DISCUS assessment, to monitor the side effects of the Haloperidol. R21's chart did not reveal side effect monitoring documented for Sertaline following medication increase.

A pharmacy note from consulting pharmacist (CP)-B dated 12/2/16, indicated a DISCUS assessment was not available in the chart. Subsequent pharmacy notes from CP-A and CP-B did not address lack of DISCUS assessment. Pharmacy notes from 12/2/16, did

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not address lack of side effect monitoring for Sertaline.

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.

On 8/17/17, at 8:08 a.m. the DON stated a baseline DISCUS assessment should be done upon admission, upon initiation of a newly prescribed antipsychotic medication, a significant change and/or every 6 months. Later that day at 11:10 a.m., the DON verified no DISCUS assessment had been completed since R24 since admission and was unable to locate documentation to confirm a DISCUS had been completed for R21.

Review of the undated facility policy Antipsychotic Medication Use indicated the nursing staff would monitor for side effects including tardive dyskinesia (TD) .

R14 was admitted on 4/10/08, and the Physician Order Report dated 8/17/17, directed staff to administer Celexa 10 mg by mouth (PO) daily for depression/mood; initiation on 8/1/17, and Risperidone 2 mg, PO at bed time for delusional related to other schizophrenia.

The Care Area Assessment (CAA) dated 2/5/17, identified R14 with diagnoses of "schizophrenia, depression and psychosis" which required psychotropic medications prescribed by the primary care provider. It also indicated R14 was at risk for Tardive Dyskinesia.

The Review of consultant pharmacist's

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medication regimen dated 4/3/17, stated R14 "takes citalopram 10 mg daily." According to this record, the medication was due per state and federal law to evaluate the potential dose reduction. The CP also stated R14 has "minimal to no depression and may no longer require treatment". However, the facility did not follow through the CP's recommendation.

Pharmacy consultant note dated 3/7/17, revealed resident was on Benztropine for a long period of time. "please assess if you are still desired benefit of this medication for [R14] OR if a DC [discontinue] is appropriate". However, the facility did not follow through the CP's recommendation.

Care plan dated 5/5/17, indicated R14 had been used psychotropic medication to manage behaviors of "depression, schizophrenia, psychosis". Staff were directed to administer antipsychotic medication as ordered by physician and to monitor side effect and effectiveness of medication every shift. The care plan dated 4/28/17, also indicated R14 had major depressive disorder and staff were directed to administer medication as ordered and to monitor and document the side effect and effectiveness of the medication; however, the facility lack documentation Risperidone and Celexa were adequately monitored.

On 8/16/17, at 8:20 a.m. registered nurse (RN)-D stated they do not have a side effect monitoring system; stating, "we will put the side effect monitoring and behavior monitoring as soon as possible".

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

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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."

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.

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.

The physician orders 8/1/17, indicated R30 was 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.

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

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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, 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 8/1/17, for the monthly medication review and had not made a recommendation for a DISCUS to be completed for R30. CP-A stated he did not believe he had given any recommendation for any resident at the facility to have TD monitoring completed.

On 8/17/17, at 1:27 p.m. DON stated she

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21535	Continued From page 25 expected staff to follow residents' care plans. An undated policy provided by the facility Antipsychotic Medication Use indicated, " ... 14. Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the Attending Physician: ... tardive dyskinesia ..." An undated facility policy "Psychotropic Medication Use" indicated, "All psychotropic medications will be used within the dosage guidelines listed... Or clinical justification will be documented for dosages that exceed the listed guidelines for more than 48 hours." SUGGESTED METHOD OF CORRECTION: The director of nursing or pharmacist could in-service all staff responsible for medication use on the need to ensure adequate monitoring is conducted to identify adverse effects in a timely manner. They could initiate a random review of charts to ensure this happened, and could report findings to the facility's quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21535		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician.	21565		9/20/17

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21565	Continued From page 26 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an assessment had been completed for safe self-administration of medication (SAM) for 1 of 2 residents (R46) observed self-administering a nebulizer medication. Findings include: R46's annual Minimum Data Set (MDS) assessment dated 6/14/17, indicated a brief interview for mental status (BIMS) score of 12, The activities of daily living assessment identified all activities as extensive assistance (bed mobility, transfer, walk in room and corridor, locomotion on and off unit, dressing, toilet use and personal hygiene) with the exception of eating which was coded independent. R46's current physician orders included Pulmicort Suspension 0.5 milligrams (mg) per 2 milliliters (ml); inhale orally two times a day related to idiopathic pulmonary fibrosis (scar tissue in the lungs that causes progressive damage). Additionally, R46 also received an as needed order for DuoNeb Solution 0.5-2.5; 3 mg per 3 ml, to be given for shortness of breath, the medication administration record indicated this medication had been administered three times since 7/1/17. On 8/16/17, at 8:03 a.m. RN-B was observed to enter R46's room to administer a nebulizer treatment. RN-B filled the nebulizer with the medication, and handed R46 the mask. RN-B then stated to the surveyor that she starts the nebulizer and the resident will then be responsible to keep the mask on independently.	21565	Corrected	

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21565	Continued From page 27 R46 was observed to hold the mask up to his face while the nebulizer treatment began. RN-B left the room to continue with the medication pass. Several minutes later the RN-B returned to the room to remove the nebulizer mask and treatment. At that time, R46 still had the mask up to his face, which he removed when the nurse arrived. R46 was here to state that he thought the treatment was finished. RN-B verified the treatment was complete by examining the nebulizer chamber, she then rinsed the chamber and left the mask and chamber to air dry on paper towels. R46's self-administration assessment dated 6/7/17, indicated R46 did not have the cognitive or functional ability to self-administer his medications. In an interview with the MDS Coordinator on 8/16/17, at 2:45 p.m. she stated R46 had been in and out of the facility due to being "unable to succeed at home". The MDS Coordinator stated she had completed the initial brief assessment for self-administration of medications following the resident's readmission to the facility. She said the SAM assessment had been conducted to determine whether R46 wished to self-administer medications and to determine whether he had the cognitive ability to perform the task. The MDS Coordinator further stated she could not recall having done any further assessment of R46's ability to conduct self-administration of medications since 6/7/17. The director of nursing stated during interview on 8/17/17, at 9:45 a.m. that another SAM assessment should have been conducted prior to R46 being allowed to self administer the nebulizer treatment.	21565		

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21565	Continued From page 28 The facility's policy titled Self-Administration of Medications, indicated residents of the facility may self-administer their medications if it was determined they were capable of doing so. "As part of their overall evaluation, the staff and practitioner will assess the resident's mental and physical abilities, to determine whether a resident is capable of self-administering medications." SUGGESTED METHOD OF CORRECTION: The director of nurses (DON) or designee could develop systems to ensure regulatory compliance and resident safety during self administration opportunities. The DON or desginee could educate all appropriate staff on these systems. The DON or designee could develop monitoring to ensure ongoing compliance and share those results with the facility's quality committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21565		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement 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	21665	Corrected	9/20/17

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21665	Continued From page 29 randomly reviewed (R9, R27, R38, R42) for potential environmental hazards. Findings include: R37 was observed on 8/16/17, at 11:34 a.m. laying in bed with 1/4 side rails bilaterally on the bed in the up position. On 8/16/17, at 3:19 p.m. R37's side rail was observed in the up position. The director of nursing (DON) looked at the rail with the surveyor. It was noted the quarter rail on the door 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 side rail assessment. R37's annual Minimum Data Set (MDS) dated 6/12/17, indicated R37 was rarely understood, had short and long term memory problems, and had moderately impaired decision making. This MDS also indicated R37 had inattention and disorganized thinking, but experienced no behaviors and no rejection of cares. The MDS indicated R37 required limited assistance of staff for locomotion on unit. The corresponding Care Area Assessment (CAA) dated 6/12/17, indicated R37 had advanced dementia and needed staff assistance with activities of daily living. The CAA also indicated R37 usually had a steady gait but at times needed staff assistance due to unsteadiness.	21665		

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21665	Continued From page 30 R37's careplan dated 7/1/16, indicated R37 was able to transfer independently with supervision and stand by or limited assist. The careplan also indicated R37 was able to reposition herself in bed. However, the careplan did not include the use of a quarter (1/4) side rail. During an interview with nursing assistant (NA)-B on 8/16/17 at 1:53 p.m., NA-B verified R37 required staff assistance to walk. NA-B stated R37 had dementia but self transferred and utilized the quarter side rail to get out of bed. On 8/16/17, at 2:24 p.m. NA-A stated R37 needed stand by assist for walking and was steady on her feet. NA-A also stated R37 used her side rails to pull herself up from bed. NA-A further stated if a resident's side rails moved more than a little she would call the maintenance to fix. On 8/16/17, at 2:26 p.m. registered nurse (RN)-C stated nurses did not complete the side rail assessments but that the MDS Coordinator and the assistant DON (ADON) completed the side rail assessments. At 2:31 p.m. the MDS Coordinator stated when she completed the side rail assessments she would ask the resident whether they wanted the rail, and that she would complete the side rail assessments quarterly. The MDS Coordinator further explained that she physically checked the side rails when she completed an assessment to make sure they were safe, and that there were no gaps between the rail and the bed. The MDS Coordinator stated when a side rail was loose she would call maintenance to tighten or replace the rail. The MDS Coordinator verified R37's most recent side rail assessment was dated 6/23/16.	21665		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00407	A. BUILDING: _____ B. WING _____	08/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21665	Continued From page 31 On 8/16/17, at 2:51 p.m. the DON stated her expectation was that side rails would be physically checked when assessed to ensure they were safe. The DON also stated would follow standard practice protocol. On 8/17/17, at 8:22 a.m. the DON stated too much movement in a side rail could cause balance problems for a resident attempting to hold on to it when getting up. On 8/17/17, at 9:07 a.m. the ADON stated she completed side rail assessments upon admission, quarterly, at the time of a significant change, and when there were mobility changes. However, the ADON stated she did not physically check the side rails for safety because it was not identified on the form. On 8/17/17, at 10:02 a.m. RN-B stated R37 gets herself in and out of bed herself. R18's admission MDS dated 7/18/17, indicated R18's cognition was severely impaired and that R18 needed staff assist with transfers and bed mobility. R18's CAA dated 7/18/17, indicated R18 had a balance deficit related to compression fracture and needed limited to extensive assist with transfers, toileting and ambulation. It was also indicated R18 was at risk for falls with serious injury. R18's care plan dated 7/28/17, indicated R18 used grab bars to maximize independence with turning and repositioning in bed, and was able to transfer with supervision using four wheeled walkers. During an initial observation on 8/14/17, at 7:21 p.m. R18's 1/4 side rail was noted not to fit	21665		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00407	A. BUILDING: _____ B. WING _____	08/17/2017

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21665	Continued From page 32	21665		

properly. The rail was noted to move from the bed outward about two inches. At the time of the observation, R18 stated to the surveyor, "That is one thing I want them to fix."

On 8/16/17, at 7:04 a.m. R18 was observed to be laying in bed with 1/4 side rail up on the door side.

On 8/17/17, at 8:21 a.m. the surveyor and the DON went to R18's room to look at the 1/4 side rail. The DON verified the 1/4 side rail was loose. She stated, "What concerns me most is the movement back and forth". The DON stated there was excessive motion of the side rail and that it was not stable.

Other observations of siderails revealed the following side rails that were not securely attached to the bed:

R42's 1/4 side rail on the door side was observed in the up position on 8/14/17, at 7:11 p.m. The rail was observed to move from the mattress outward about 2-3 inches.

R38's 1/4 side rail on the door side was observed in the up position on 8/15/17, at 9:56 a.m. The rail was observed to move from the mattress outward about 3-4 inches.

R27's 1/4 side rail on the door side was observed in the up position on 8/15/17, at 9:59 a.m. The rail was observed to move from the mattress outward about 3-4 inches.

R9's 1/4 side rail on the door side of the bed was observed in up position on 8/15/17, at 3:57 p.m. The rail was observed to move from the mattress outward about 3-4 inches.

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	00407	A. BUILDING: _____ B. WING _____	08/17/2017

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21665	Continued From page 33 SUGGESTED METHOD OF CORRECTION: The administrator, director of maintenance, or designee could update facility policies and procedures related to auditing and tracking care equipment to ensure it remains safe. Audits could also be completed to ensure resident care equipment is in safe operating condition. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21665		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/16/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Crossroads Care Center was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically 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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/16/2017**

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K 000	Continued From page 1 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and 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: 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. The facility has smoke detection in the corridors 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 000		
K 222 SS=F	NFPA 101 Egress Doors	K 222		9/20/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/16/2017**

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K 222	Continued From page 2 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the 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. 18.2.2.2.5.2, 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	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 222	Continued From page 3 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, 19.2.2.2.4 This STANDARD is not met as evidenced by: Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the	K 222	The plastic squeeze device that was on the exit door E-100 has been removed from the door knob. This device was removed on 9/12/17. The Environmental Supervisor, Dean VonHoltum will be responsible for the correction and monitoring to prevent a reoccurrence of this deficiency.	

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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. 18.2.2.2.5.2, 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, 19.2.2.2.4. This deficient practice could affect 42 out of 42	K 222		

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K 222	Continued From page 5 residents. FINDINGS INCLUDE: On facility tour between 8:00 AM and 12:00 PM on 08/16/2017, the Exit door E-100 was observed with a plastic squeeze device on the door knob. Placement of this device on an egress door requires two actions to open the exit door. This deficient practice was verified by the Facility Maintenance Director.	K 222		
K 353 SS=E	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to maintain the automatic sprinkler system in accordance with 9.7.5, 9.7.7, 9.7.8, and NFPA	K 353	The Environmental Supervisor will take over the duties of making sure the sprinkler system is tested on a quarterly	9/20/17

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	245395	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/16/2017**

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K 353	Continued From page 6 25. This deficient practice could affect 42 out of 42 residents. Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 FINDINGS INCLUDE: On facility tour between 8:00 AM and 12:00 PM on 8/16/2017, observation revealed that documentation could not be located to indicate that the quarterly fire sprinkler inspection occurred during the 1st and 2nd quarters of 2017. This deficient practice was verified by the Facility Maintenance Director.	K 353	basis. Midwestern Mechanical, Inc. conducts a semi-annual test and annual test of the sprinkler system. The next completion date for testing and maintenance of the sprinkler system will be October 2017. Documentation from Midwestern Mechanical,Inc. shows that they did maintenance and testing of the sprinkler system on 1/26/17 and 7/17/17. The Environmental Supervisor, Dean VonHoltum will be responsible for the correction and monitoring to prevent a reoccurrence of deficiency.	