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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RU7P

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00784

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245436**

2.STATE VENDOR OR MEDICAID NO.
(L2) **803692000**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARKVIEW CARE CENTER WELLS INC**
(L4) **55 TENTH STREET SOUTHEAST**
(L5) **WELLS, MN** (L6) **56097**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2009**

6. DATE OF SURVEY **04/01/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
**09/30**

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A, 5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 55 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

**See Attached Remarks**

17. SURVEYOR SIGNATURE Date :
Kathy Hahn, HFE NEII 04/22/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 04/22/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
**03/01/1987**
(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
File Name: 5436r13.pdf

Posted 5/3/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
**04/12/2013**
(L33)

DETERMINATION APPROVAL

CCN: 24-5436

At the time of the February 15, 2013 extended survey the facility was not in substantial compliance with Federal participation requirements. The conditions in the facility constituted Substandard Quality of Care (SQC) to residents health or safety.

A Post Certification Revisit (PCR) was completed by this Department and verified correction of the deficiencies issued pursuant to the extended survey completed February 15, 2013, effective March 27, 2013. Please refer to the CMS-2567b for Health.

Documentation supporting the facility's request for a continuing waiver involving K67, approval of the waiver request was recommended.

Effective March 27, 2013 the facility is recommended for 55 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

CMS Certification Number (CCN): 24-5436

April 22, 2013

Mr. Robert Johannsen, Administrator
Parkview Care Center Wells Inc
55 Tenth Street Southeast
Wells, Minnesota 56097

Dear Mr. Johannsen:

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

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

Effective March 27, 2013 the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 skilled nursing facility beds located in rooms.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K67.

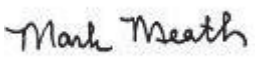
If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency or renew your request for waiver in order to continue your participation in the Medicare Program.

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

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

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

Sincerely,



Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

April 22, 2013

Mr. Robert Johannsen, Administrator
Parkview Care Center Wells Inc
55 Tenth Street Southeast
Wells, Minnesota 56097

RE: Project Number S5436022

Dear Mr. Johannsen:

On March 5, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an extended survey, completed on February 15, 2013. Conditions in the facility constituted Substandard Quality of Care (SQC) to resident health or safety. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On April 1, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on February 15, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 27, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 15, 2013, effective March 27, 2013 and therefore remedies outlined in our letter to you dated March 5, 2013, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under K67 at the time of the February 15, 2013 extended survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

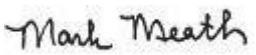
However, as we notified you in our letter of March 5, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 15, 2013.

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

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

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

Sincerely,



Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5436r13.rtf

## Post-Certification Revisit Report



| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245436 | A. Building<br>B. Wing | 4/1/2013 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| PARKVIEW CARE CENTER WELLS INC | 55 TENTH STREET SOUTHEAST<br>WELLS, MN 56097 |

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

| (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|---|---|---|---|---|---|
| ID Prefix **F0156**<br>Reg. # **483.10(b)(5) - (10), 483.10(b)(1)**<br>LSC | Correction Completed **03/27/2013** | ID Prefix **F0167**<br>Reg. # **483.10(g)(1)**<br>LSC | Correction Completed **03/27/2013** | ID Prefix **F0225**<br>Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)**<br>LSC | Correction Completed **03/27/2013** |
| ID Prefix **F0226**<br>Reg. # **483.13(c)**<br>LSC | Correction Completed **03/27/2013** | ID Prefix **F0329**<br>Reg. # **483.25(l)**<br>LSC | Correction Completed **03/27/2013** | ID Prefix **F0428**<br>Reg. # **483.60(c)**<br>LSC | Correction Completed **03/27/2013** |
| ID Prefix **F0465**<br>Reg. # **483.70(h)**<br>LSC | Correction Completed **03/27/2013** | ID Prefix **F0493**<br>Reg. # **483.75(d)(1)-(2)**<br>LSC | Correction Completed **03/19/2013** | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| Reviewed By | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| State Agency | MM/MK | 04/21/2013 | 28651 | 04/01/2013 |
| Reviewed By<br>CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

| Followup to Survey Completed on: | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? | YES | NO |
|---|---|---|---|
| 2/15/2013 | | | |

MINNESOTA MDH DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

April 22, 2013

Mr. Robert Johannsen, Administrator
Parkview Care Center Wells Inc
55 Tenth Street Southeast
Wells, Minnesota 56097

Re: Enclosed Reinspection Results - Project Number S5436022

Dear Mr. Johannsen:

On April 1, 2013 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 February 15, 2013, with orders received by you on March 11, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File 5436r13Lic.rtf

# State Form: Revisit Report

| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 00784 | A. Building<br>B. Wing | 4/1/2013 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| PARKVIEW CARE CENTER WELLS INC | 55 TENTH STREET SOUTHEAST<br>WELLS, MN 56097 |

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

| (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|---|---|---|---|---|---|
| ID Prefix **21530**<br>Reg. # **MN Rule 4658.1310 A.B.C**<br>LSC | Correction Completed **03/27/2013** | ID Prefix **21535**<br>Reg. # **MN Rule4658.1315 Subp.1 ABC**<br>LSC | Correction Completed **03/27/2013** | ID Prefix **21695**<br>Reg. # **MN Rule 4658.1415 Subp. 4**<br>LSC | Correction Completed **03/27/2013** |
| ID Prefix **21800**<br>Reg. # **MN St. Statute144.651 Subd. 4**<br>LSC | Correction Completed **03/27/2013** | ID Prefix **21980**<br>Reg. # **MN St. Statute 626.557 Subd. 3**<br>LSC | Correction Completed **03/27/2013** | ID Prefix **21995**<br>Reg. # **MN St. Statute 626.557 Subd. 4**<br>LSC | Correction Completed **03/27/2013** |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| Reviewed By | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| State Agency | MM/MK | 04/22/2013 | 28651 | 04/01/2013 |
| Reviewed By<br>CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

| Followup to Survey Completed on: | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? | YES | NO |
|---|---|---|---|
| 2/15/2013 | | | |

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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RU7P

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00784

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245436**

2.STATE VENDOR OR MEDICAID NO.
(L2) **803692000**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARKVIEW CARE CENTER WELLS INC**
(L4) **55 TENTH STREET SOUTHEAST**
(L5) **WELLS, MN** (L6) **56097**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2009**

6. DATE OF SURVEY **02/15/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
**09/30**

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

**X** B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: ***B, 5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 55 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

**See Attached Remarks**

17. SURVEYOR SIGNATURE Date :
Kathy Hahn, HFE NEII 04/08/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 04/12/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
**03/01/1987**
(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
Posted 04/12/2013 CO. RU7P

K67 LSC Waiver PDF_ACO 04/12/2013 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL
Emailed CMS 04/12/2013 CO.

**C&T REMARKS - CMS 1539 FORM** **STATE AGENCY REMARKS**

CCN: 24-5436

At the time of the February 15, 2013 extended survey the facility was not in substantial compliance with Federal participation requirements. The conditions in the facitliy consituted SubsStandard Quality of Care (SQC) to residents health or safety. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

Documentation supporting the facility's request for a continuing waiver involving K67, approval of the waiver request was recommended. Refer to the CMS 2786R Provision Number K84 Justification Page.

MINNESOTA MDH DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

Certified Mail # 7011 2000 0002 5148 9370

March 5, 2013

Ms. Jessica Raad, Administrator
Parkview Care Center Wells Inc
55 Tenth Street Southeast
Wells, Minnesota 56097

RE: Project Number S5436022

Dear Ms. Raad:

On February 15, 2013, an extended 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. In addition, at the time of the February 15, 2013 extended survey the Minnesota Department of Health completed an investigation of complaint number .

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

**Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;**

**Appeal Rights - the facility rights to appeal imposed remedies;**

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

**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:

Maria King
Minnesota Department of Health
Mankato Place
12 Civic Center Place Plaza, Suite # 2105
Mankato, Minnesota 56001

Telephone: (507) 344-2716
Fax: 507) 344-27123

**OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 27, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 27, 2013 the following remedy will be imposed:

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

**SUBSTANDARD QUALITY OF CARE**

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Parkview Care Center Wells Inc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective February 15, 2013. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

**APPEAL RIGHTS**

Pursuant to the Federal regulations at 42 CFR § 498.3(b)(13)(ii) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. The CMS Region V Office has authorized this Department to notify you of your appeal rights. If you disagree with the finding of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following

address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Oliver Potts, Chief
330 Independence Avenue, SE
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

**PLAN OF CORRECTION (PoC)**

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

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

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

**PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for their respective deficiencies (if any) is acceptable.

**VERIFICATION OF SUBSTANTIAL COMPLIANCE**

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

**Original deficiencies not corrected**

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

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

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

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

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

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

If substantial compliance with the regulations is not verified by May 15, 2013 (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 August 15, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

**INFORMAL DISPUTE RESOLUTION**

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day

period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

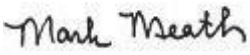
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Sincerely,



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

Enclosure

cc: Licensing and Certification File 5436s13.rtf

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245436 | A. BUILDING _____ B. WING _____ | 02/15/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PARKVIEW CARE CENTER WELLS INC | 55 TENTH STREET SOUTHEAST WELLS, MN 56097 |

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| F 000 | INITIAL COMMENTS<br><br>A standard recertification survey was conducted and an extended survey was also completed at the time of the standard survey.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance.<br><br>Upon receipt of an acceptable 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 | RECEIVED<br>MAR 25 2013<br>COMPLIANCE MONITORING DIVISION<br>LICENSE AND CERTIFICATION | |
| F 156 SS=D | 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES<br><br>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.<br><br>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for | F 156 | POC Approved mtcing 3/25/13<br><br><u>F-156 It is our intent to comply with the regulation</u><br><u>Notice of Rights, Rules, Services and Charges.</u><br><br>R25, R11 AND R169'S records have been reviewed and appropriate Medicare notices have been issued. Henceforth, all Medicare denials will be completed according to regulation. Policy and procedure for Medicare denials was reviewed and updated and education for those giving denial notices was provided. All residents with Medicare denials being sent will be reviewed every two weeks and monthly until 100 percent compliance. Reports shall be presented to the QAA Committee for comment & review. Corrective action will be completed by March 27, 2013. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert J Thompson — TITLE: Administrator — (X6) DATE: 3-27-13

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.

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 156 | Continued From page 1<br>which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.<br><br>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.<br><br>The facility must furnish a written description of legal rights which includes:<br>A description of the manner of protecting personal funds, under paragraph (c) of this section;<br><br>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.<br><br>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and | F 156 | | |

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| F 156 | Continued From page 2<br>advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.<br><br>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.<br><br>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.<br><br>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to provide the required Medicare | F 156 | | |

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| F 156 | Continued From page 3<br>(MC) denial notices for 3 of 3 residents (R25, R11, R69) discharged from MC services.<br><br>Findings include:<br><br>Three residents who were given MC denial notices, received only the expedited notice for discharge from MC services without reciept of a detailed notice to describe the specific reasons for their discharge from MC, and without ensuring the residents had been informed of their rights to request a demand bill be submitted.<br><br>R25 had been given an expedited notice of noncoverage for MC on 8/30/12. The expedited notice indicated that MC would probably not pay for her current skilled nursing services after 8/30/12. R25 was not given the detailed notice notifying her of the right to request a demand bill.<br><br>R11 had been given an expedited notice of noncoverage for MC on 11/7/12. The expedited notice indicated that MC would probably not pay for her current skilled nursing services after 11/7/12. R11 had been utilizing MC coverage due to her need for skilled physical therapy. The resident was not given a detailed notice notifying her of the right to request a demand bill.<br><br>R69 had been given an expedited notice of noncoverage for MC on 11/29/12. The expedited notice indicated that MC would probably not pay for his current skilled nursing services after 11/29/12. R69 was not given a detailed notice notifying him of his right to request a demand bill.<br><br>On 2/13/12 at 11:30 a.m., registered nurse (RN) -C, responsible for giving residents their MC | F 156 | | |

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

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| F 156 | Continued From page 4<br>denial notices, was interviewed. She stated she was not aware that she had to give both the detailed notice and the expedited notices of noncoverage for MC to residents. RN-C confirmed that each of these residents had been given denials due to either goals met or lack of progress, and that each of these residents was otherwise paying privately for their stay at the nursing home. | F 156 | | |
| F 167 SS=B | 483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE<br><br>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.<br><br>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and document review, the facility failed to post the results of their most recent recertification survey. This had the potential to affect all residents in the facility.<br><br>Findings include:<br><br>During observations of the facility during an intial tour at 6:55 a.m. on 2/12/13, a binder was noted available for resident/family/visitor use, labeled survey results. However, the results of the most recent recertification survey were not available. | F 167 | F167 Right to Survey Results Readily Accessible<br><br>1. The Facilities compliance to post the most recent survey and plan of corrections was reviewed by the Administrator.<br>2a. The Administrator recovered the previous year survey results and plan of corrections and posted near the main entrance to the nursing home and in the main hallway to be accessible to residents and visitors, on March 1, 2013.<br><br>2b. The Administrator or designated person will ensure the survey results are posted on a daily basis for one week, then weekly for 4 weeks to achieve 100% compliance.<br><br>2c. The administrator or designee will place results of this Plan of Corrections immediately, accessible to residents, visitors, and staff. | |

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| F 167 | Continued From page 5<br>The results made available were from the survey conducted in 2011.<br>During an additional observation on 2/14/13 at 8:00 a.m., the survey results available for review were from 2011. During interview with the director of nursing at that time, she verified the available survey results were not from the most recent survey. | F 167 | 2d. The administrator or designee will report to the Quality Assurance committee quarterly to ensure the compliance to survey accessibility by residents, visitors, and staff.<br><br>2e. Corrective Action will be complete by March 27, 2013. | |
| F 225<br>SS=D | 483.13(c)(1)(ii)-(iii), (c)(2) - (4)<br>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. | F 225 | <u>F225- It is our intent to comply with the regulation Investigate/Report/Allegations/Individuals</u><br><br>R7, R77 , R42 and R10's records were reviewed and appropriate reports were submitted to the CEP & SA.<br>All instances of unknown bruising, missing items, elopement, etc. shall be reported per Facility protocol & regulation.<br>The Vulnerable Adult policy and procedure was reviewed & revised. Education was provided to all staff regarding revisions to the VAA P&P.<br><br>All incidents will be reviewed by the Interdisciplinary Team and be reviewed/audited again, bi-weekly for | |

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| F 225 | Continued From page 6<br>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure they reported incidents of unknown origin in a timely manner to the administrator and State agency for 5 of 5 allegations reviewed (R7, R77, R42, R10 ). They also failed to ensure they conducted a comprehensive investigation for 1 of 2 incidents of unknown origin (R10 ).<br><br>The following allegations were provided by the social worker:<br><br>1) An allegation of theft of property had been reported to the social worker on 5/18/12. According to the report, on 5/17/12, R7 and R77 had reported to the nurse that their wallets were missing. These reports were not forwarded to the social worker until 5/18/12. Although law enforcement was notified on 5/18/12, the social worker had not submitted a report to MDH until 5/22/12.<br><br>2) An allegation of alleged elopement had been reported to the social worker on 8/20/12. According to the report, on 8/20/12, R42 had left the facility grounds without notifying any staff. | F 225 | 90 days. Then, weekly until 100% compliance is achieved.<br><br>Summary findings shall be presented to the QAA Committee for review & comment.<br><br>Date of Correction: March 27, 2013 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 225 | Continued From page 7<br>When staff noticed he was missing at 2:30 p.m. they had done a search of the grounds and had been unable to locate the resident. The report indicated the resident had ultimately been found a short time later alone, in his personal home. Although elopement interventions were implemented upon the resident's return to the facility, no report had been submitted to MDH until 8/21/12.<br><br>During additional information with the DON on 2/14/13 at 10:30 a.m., she stated she did not always immediately report allegations but tried to determine the cause first. When asked to review the system for determining what to report, the DON said she didn't keep a specific file for that, but would review her QA (quality assurance) data related to incidents. The DON also stated that they'd been told they were over reporting, by their common entry point contact, and that she'd been trying to determine the cause of any bruises of unknown origin prior to reporting so that they wouldn't report things they had identified likely causes for.<br><br>R10 was observed to have extensive bruising bilaterally on her arms, hands and lower outer legs that were of unknown origin. However, the facility had not reported the bruising, nor conducted an investigation to determine the potential cause of the bruising.<br><br>During observations made of R10 skin on 2/14/13 at 2:25 p.m., with nursing assistant (NA)-A, NA-B, and licensed practical nurse (LPN)-A, LPN-A measured the bruises on R10's hands, arms and outer legs. The following measurements were identified: | F 225 | | |

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| F 225 | Continued From page 8<br><br>1) Top of right and left hand, 7.0 cm (centimeters) by 6.0 cm and dark purplish in color.<br>2) Top of both wrists, 6.0 cm by 4.0 cm and dark purplish in color.<br>3) Outer aspect of right upper arm, 6.0 cm by 5.0 cm and reddish/purple in color.<br>4) Outer aspect of upper left arm, 6.0 cm by 5.0 cm and dark purplish in color.<br>5) Outer aspect of the left mid arm near elbow, 2.0 cm by 1.0 cm and dark purplish in color.<br>6) Outer aspect of right lower leg near the knee, 3.0 cm by 4.0 cm and dark purplish in color.<br>7) Outer aspect of right lower leg near the ankle, 3.0 cm by 7.0 cm and dark purplish in color.<br>8) Outer aspect of the left lower leg near the knee, 7.0 cm by 5.5 cm and dark purplish in color.<br>9) Outer aspect of left lower leg calf area, 8.0 cm by 5.5 cm and dark purplish in color.<br>10) Outer aspect of the left lower leg near the ankle, 6.0 cm by 4.0 cm and dark purplish in color.<br><br>During the observation, NA-A and NA-B both indicated R10 had experienced reoccurring bruising for several months. However they stated they were unsure of the causal factors of the bruising. They also stated the bruises on the residents legs could be from her bumping them on the wheelchair leg rests. NA-A and B, both indicated R10 should have arm protectors on her arms as well.<br><br>Interview with LPN-A on 2/14/13 at 2:30 p.m. indicated she was aware of the bruises on R10's body and that the resident's bruises continued to reoccur over a period of time. LPN-A was not | F 225 | | |

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| F 225 | Continued From page 9<br>sure when the resident's current bruises had been identified, but verified that they looked new. LPN-A included she was uncertain of the causal factors of the residents current bruises and could not inform the surveyor if the bruising was improving. She indicated leg protectors had been applied to R10's legs to protect her from bumping them on her wheelchair leg rests, but confirmed that the resident continues to bruise even with the protectors on. LPN-A further indicated R10 should have arm protectors on as well.<br><br>Observation on 2/14/13 at 2: 45 p.m. and on 2/15/13 at 10:00 a.m., R10 was laying in bed on her right side. The resident did not have the arm protectors on even though LPN-A and NA-A and B indicated the resident should have them on for protection. During observation it was also observed that the siderails were not padded per the plan of care.<br><br>Review of the plan of care for R10, identified the resident as having problems with skin breakdown due to poor skin integrity. It further included the resident has fragile skin and bruises and tears easily. Approaches: 1) observe with cares for prolonged areas of redness, blisters, rash and pain. 2) geri leg protectors on legs for protection when out of bed. 3) pad siderails with sheepskin. 4) do not pull or grab residents arms when turning in bed and assist by using her shoulder, hip and buttock area to turn her.<br><br>Review of the skin treatment measurement form dated 1/1/13, identified R10 with a hematoma on the lower right arm, that measured 12 cm in size, purplish in color and swollen. There was no documentation if the bruising had resolved. No | F 225 | | |

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| F 225 | Continued From page 10<br>other bruises were identified on the form.<br><br>Review of the incident report and nurse's note dated 1/10/13, indicated R10 had been observed to have a bruise/hematoma on the left arm when staff were assisting her to get up that morning. Documentation indicated the area had measured 12 cm in diameter. The note further indicated the staff were uncertain of the causal factor, but thought it might have been caused from repositioning. The note further indicated that staff were unable to determine any new interventions, but would continue the current interventions of not using the resident's arms with turning. No other documentation regarding R10's current bruises on her legs, hands and arms were found.<br><br>Interview with the DON on 2/15/13 at 9:30 a.m., confirmed that an investigation had not been completed in regards to the casual factors of R10's extensive bruising and that no report had been made to MDH. The DON further included she thought the staff had been monitoring the bruising, and stated she thought maybe the EZ stand (mechanical lift) was the cause of the bruising to the resident's arms, but could not be certain. The DON stated R10 had been using the Hoyer lift (another type of mechanical lift) for the past couple of weeks, but that the bruising had persisted. The DON stated there had been discussion with the staff in the past to use arm protectors on R10's arms, but confirmed this had not been implemented. She further included that the weekly shower sheets were to be filled out and turned into her for further investigation, but verified the staff might not fill them out each week since the bruising was reoccurring. | F 225 | | |

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| F 225 | Continued From page 11<br>The facility's Vulnerable Adult policy last revised 2/2011, was reviewed on 2/14/13. The policy included directions for protection and reporting: "All staff members are mandated to report when: ...3) A resident has an unexplained injury." Definitions attached to the policy included: "Injuries of Unknown Source- An injury should be classified as an injury of unknown source when both of the following conditions are met: 1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident: and 2) The injury is suspicious because of the extent of the injury or the location of the injury...or the number of injuries observed at one particular point in time or the incidence of injuries over time." | F 225 | | |
| F 226 SS=F | 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to develop and implement appropriate policies for the immediate reporting of abuse, neglect and mistreatment to the facility administrator and State agency for 5 of 5 resident incidents (R7, R77, R42, R8 and R10) reviewed in the sample for abuse prohibition. This deficient practice had the potential to affect 44 of 44 residents currently residing in the facility, and resulted in substandard quality of care. | F 226 | F-226- It is our intent to comply with the regulation The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property.<br><br>See F225:<br>Date of Correction: March 27, 2013 | |

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| F 226 | Continued From page 12<br><br>Findings include:<br><br>The facility's Vulnerable Adult policy last revised 2/2011, was reviewed on 2/14/13. The policy indicated timelines for reporting to include: "After protecting the resident(s), immediately report the situation to the supervisor and Administrator. This will start the investigation. If it is determined that a report is to be made to the Common Entry Point (CEP) and the State Electronic notification website, do so as soon as possible, no longer than 24 hours from the time of initial knowledge that the incident occurred..." The directions for investigating and follow up for allegations included: "When the Administrator, or designee, is notified of the incident, they will review the act and the information collected through interview and documentation. They will clarify the information and determine if all information has been collected. If they determine the incident requires reporting, they will confirm if the report has been made. If not, they will complete the CEP form, contact the in-take worker and submit the form. In addition, if the State on-line report has not been completed, the Administrator, or designee, will complete this process. There may be times when the report is not required to go to the CEP but is reportable to the website (such as physical or verbal abuse between residents)..." The policy also included these additional directions for minimizing the risk of abuse: "The facility designated reporter will report incidents to MDH (Minnesota Department of Health) via a secure web site. This is a two step process, initially reporting the incident and then submitting an investigative report. The initial report must be made by electronic submission to the MDH and | F 226 | | |

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| F 226 | Continued From page 13<br>also to the CEP immediately, meaning as soon as possible but not more than 24 hours after the discovery of the incident." The facility's policy also included directions for protection and reporting: "All staff members are mandated to report when: ...3) A resident has an unexplained injury." Definitions attached to the policy included: "Injuries of Unknown Source- An injury should be classified as an injury of unknown source when both of the following conditions are met: 1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident and 2) The injury is suspicious because of the extent of the injury or the location of the injury...or the number of injuries observed at one particular point in time or the incidence of injuries over time."<br><br>During interview with the facility's director of nursing (DON) on 2/14/13 at 9:45 a.m., the DON stated staff were supposed to immediately report allegations of abuse to her and that she'd then report to the administrator. When asked to review reports, the DON directed the surveyor to the social worker.<br><br>Allegations of abuse/neglect were requested for review from the facility's social worker on 2/14/13 at 10:00 a.m. The social worker stated at that time that she had only reported two incidents in the past year. She said she did not keep any files of allegations they had decided not to report, and referred the surveyor to the DON. In addition, the social worker stated she did not always submit the report to MDH immediately. She stated she had understood they had up to 24 hours to report allegations. | F 226 | | |

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| F 226 | Continued From page 14<br><br>The following allegation reports were provided by the social worker:<br><br>1) An allegation of theft of property had been reported to the social worker on 5/18/12. According to the report, on 5/17/12, R7 and R77 had reported to the nurse that their wallets were missing. These reports were not forwarded to the social worker until 5/18/12. Although law enforcement was notified on 5/18/12, the social worker had not submitted a report to MDH until 5/22/12.<br><br>2) An allegation of alleged elopement had been reported to the social worker on 8/20/12. According to the report, on 8/20/12, R42 had left the facility grounds without notifying any staff. When staff noticed he was missing at 2:30 p.m. they had done a search of the grounds and had been unable to locate the resident. The report indicated the resident had ultimately been found a short time later alone, in his personal home. Although elopement interventions were implemented upon the resident's return to the facility, no report had been submitted to MDH until 8/21/12.<br><br>During additional information with the DON on 2/14/13 at 10:30 a.m., she stated she did not always immediately report allegations but tried to determine the cause first. When asked to review the system for determining what to report, the DON said she didn't keep a specific file for that, but would review her QA (quality assurance) data related to incidents. The DON also stated that they'd been told they were over reporting by their common entry point contact, and that she'd been | F 226 | | |

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| F 226 | Continued From page 15<br>trying to determine the cause of any bruises of unknown origin prior to reporting so that they wouldn't report things they had identified likely causes for.<br><br>R10 was observed to have extensive bruising bilaterally on her arms, hands and lower outer legs on 2/14/13 at 2:25 p.m. Interviews with staff, and record review, revealed the staff were unaware of the origin of the bruising. However, the facility had not reported the bruising, nor conducted an investigation to determine the potential cause of the bruising. The bruising had been measured during the observation:<br>1) Top of right and left hand, 7.0 cm (centimeters) by 6.0 cm and dark purplish in color.<br>2) Top of both wrists, 6.0 cm by 4.0 cm and dark purplish in color.<br>3) Outer aspect of right upper arm, 6.0 cm by 5.0 cm and reddish/purple in color.<br>4) Outer aspect of upper left arm, 6.0 cm by 5.0 cm and dark purplish in color.<br>5) Outer aspect of the left mid arm near elbow, 2.0 cm by 1.0 cm and dark purplish in color.<br>6) Outer aspect of right lower leg near the knee, 3.0 cm by 4.0 cm and dark purplish in color.<br>7) Outer aspect of right lower leg near the ankle, 3.0 cm by 7.0 cm and dark purplish in color.<br>8) Outer aspect of the left lower leg near the knee, 7.0 cm by 5.5 cm and dark purplish in color.<br>9) Outer aspect of left lower leg calf area, 8.0 cm by 5.5 cm and dark purplish in color.<br>10) Outer aspect of the left lower leg near the ankle, 6.0 cm by 4.0 cm and dark purplish in color.<br><br>During the observation, NA-A and NA-B both | F 226 | | |

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| F 226 | Continued From page 16<br>indicated R10 had experienced reoccurring bruising for several months. However they stated they were unsure of the causal factors of the bruising.<br><br>Interview with LPN-A on 2/14/13 at 2:30 p.m. indicated she was aware of the bruises on R10's body and that the resident's bruises continued to reoccur over a period of time. LPN-A was not sure when the resident's current bruises had been identified, but verified that they looked new. LPN-A included she was uncertain of the causal factors of the residents current bruises and could not inform the surveyor if the bruising was improving.<br><br>During interviews with staff regarding reporting, registered nurse (RN)-A stated at 3:18 p.m. on 2/14/13, that she wouldn't report a large bruise of unknown origin to anyone, but would try to investigate first, would make out an incident report and would notifiy the physician.<br><br>LPN-D stated at 3:25 on 2/14/13, that she would make out an incident report and initiate monitoring sheets, but would not otherwise report.<br><br>During additional interview with the social worker at 3:28 p.m. on 2/14/13, she reiterated she would report to the DON. She also stated she was not aware that the language in their facility policy was wrong, and stated, "that's probably because we don't have an administrator right now."<br><br>Interview with the DON on 2/15/13 at 9:30 a.m., confirmed that an investigation had not been completed in regards to the casual factors of | F 226 | | |

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| F 226 | Continued From page 17<br>R10's extensive bruising, and that the bruising had not been reported to MDH. | F 226 | | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to adequately monitor and assess clinical indications for continued use of an antidepressant for 2 of 10 residents (R26 and R32) in the sample, who were reviewed for | F 329 | F-329 It is our intent to comply with regulation -Drug regimen is free from unnecessary drugs.<br><br>R26 and R32 have had their records reviewed by the RPh And Director of Nursing for submission to the primary MD for comment.<br>The facility's protocol for monitoring medications was reviewed by the Director of Nursing and Consulting Pharmacist and revisions to the Center's protocols were implemented.<br><br>All residents on antidepressants will have had their records reviewed by the RPh on his next monthly visit. Recommendations will be sent to the primary MD for review and comment. | |

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| F 329 | Continued From page 18<br>unnecessary medication usage.<br><br>The findings include:<br><br>R26's medical record was reviewed. Current physician orders included a prescription for Celexa (an antidepressant) 20 mg (milligrams) po (orally) QD (daily). The record indicated the resident had utilized that dosage of Celexa since March of 2012. There was no documented physician justification for continued use, or any attempts at a dosage reduction since 5/23/12.<br><br>A note to the resident's physician dated 3/26/12, by RN-E included: "Please review medications. Was receiving 10 mg Celexa prior to recent hospitalization, and still is, although discharge med (medication) list says 20 mg. Now seems more depressed. Depression scale is 2." This note had not been signed by the physician.<br><br>A physician's progress note dated 5/23/12 included, "Depression: Doing well on citalopram (generic Celexa) 20 mg daily. Will consider dose reduction in September." The physician notes were reviewed from May 2012 through February 13, 2013, and there were no further recommendations related to a dosage reduction identified.<br><br>R26's medical record also failed to indicate that any monitoring of mood/behaviors was being conducted to monitor the effectiveness of the Celexa.<br><br>When interviewed on 2/14/13 at 10:00 a.m., the director of nursing offered no further information about R26's continued Celexa usage. | F 329 | Education was provided to all staff regarding target behavior reporting & monitoring.<br><br>Behavior and Mood monitoring documentation will also be reviewed with the Interdisciplinary Team, monthly and discussed with the doctor as needed.<br>All monthly reports from the consulting pharmacist are currently reviewed by the DON and correspondence/RPh recommendations with the doctor will be tracked on a monthly basis to assure timely responses.<br>To sustain compliance the facility will audit 100% of all reports received from consulting pharmacist every month for 90 days. The DON will continue to monitor all RPh recommendations and responses by the MD's. All medication for mood and associated target behaviors will be audited/monitored monthly.<br><br>Audit findings shall be presented to the QAA Committee for review & comment.<br><br>Corrective action will be completed by March 27, 2013 | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245436 | A. BUILDING _____ B. WING _____ | 02/15/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PARKVIEW CARE CENTER WELLS INC | 55 TENTH STREET SOUTHEAST WELLS, MN 56097 |

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| F 329 | Continued From page 19 | F 329 | | |

R32 had received the same dose of celexa (an antidepressant medication) 20 mg (milligrams) daily, since prior to his admission to the facility on 10/3/08, without an attempt for a dose reduction or documented medical justification regarding the continued use of the medication In addition, the residents mood symptoms had not been monitored or the past year.

R32 had been admitted to the facility on 10/3/08 . His diagnoses included: hypothyroidism, anxiety disorder and depressive disorder. Review of the most current quarterly MDS (minimum data set) dated 9/2/11, identified R32 as having no depressive symptoms. Review of the residents mood interview form dated 11/19/12, indicated the resident scored a "0" of which identified the resident as having minimal depression, but did not identify any specific symptoms. Review of the plan of care dated 6/4/12, identifies R32 as receiving a psychotropic medication related to depression. Approaches included; 1)monitor for effectiveness and possible adverse side effects of the medication. 2) review a dose reduction at least every 6 months. 3) the physician to review and address the medication.

Review of the Pharmacy consultant progress note dated 10/22/12, did not address the continued use of the celexa, nor did it identify monitoring for the continued use.

Review of the nurses notes and physician

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| F 329 | Continued From page 20<br>progress notes from 3/1/12 to 2/12/12, did not identify any depressive symptoms for R32, nor did it include justification for the continued use of the medication.<br><br>Interview with the director of nursing (DON) on 2/15/13 at 12:00 p.m. confirmed that there was no additional information for the monitoring and continued use of R32's celexa. | F 329 | | |
| F 428 SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to assure the consultant pharmacist monitored medication regimens to ensure justification and monitoring were in place for the continued use of antidepressants for 2 of 10 residents (R26 and R32) reviewed for unecessary medications.<br><br>Findings include:<br><br>The consultant pharmacist failed to make any recommendations about the continued use of | F 428 | F-428 It is our intent to comply with regulation Drug Regimen Review, Report irregular, Act on<br><br>See F329.<br><br>Corrective action will be completed by March 27, 2013 | |

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| F 428 | Continued From page 21<br>Celexa 20 mg or the lack of mood monitoring for R26.<br><br>R26's medical record was reviewed. Current physician orders included a orders for Celexa (an antidepressant) 20 mg (milligrams) po (orally) QD (daily). The record indicated the resident had utilized that dosage of Celexa since March of 2012. There had been no documented physician justification for continued use, or any attempts at a dosage reduction since 5/23/12.<br><br>A physician's progress note dated 5/23/12 included, "Depression: Doing well on citalopram (generic Celexa) 20 mg daily. Will consider dose reduction in September." The physician notes were reviewed from May 2012 through February 13, 2013, and there were no further recommendations related to a dosage reduction identified.<br><br>R26's medical record also failed to indicate that any monitoring of mood/behaviors was being conducted to monitor the effectiveness of the Celexa.<br><br>The consultant pharmacist's reviews from 5/24/12-1/23/13 were reviewed. During that time frame the consultant pharmacist had not identified any irregularities for R26's drug regimen. | F 428 | | |

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| F 428 | Continued From page 22<br><br>R32 had received celexa 20 mg daily, since prior to his admission to the facility on 10/3/08. During R32's stay at the facility, there had been no attempts at a dose reduction or documented medical justification regarding the continued use of the medication In addition, the resident's mood symptoms had not been monitored over the past year.<br><br>R32 had been admitted to the facility on 10/3/08 . His diagnoses included: hypothyroidism, anxiety disorder and depressive disorder. Review of the most current quarterly MDS (minimum data set) dated 9/2/11, identified R32 as having no depressive symptoms. Review of the resident's mood interview form dated 11/19/12, indicated the resident scored a "0" which identified the resident as having minimal depression, but did not identify any specific symptoms. Review of the resident's plan of care dated 6/4/12, identifies R32 as receiving a psychoactive medication related to depression. Approaches included: 1) monitor for effectiveness and possible adverse side effects of the medication. 2) review for dose reduction at least every 6 months. 3) the physician to review and address the medication.<br><br>Review of the Pharmacy consultant progress notes dated 10/22/12, did not address the continued use of the celexa, nor did it identify monitoring for the continued use.<br><br>Review of the nurses' notes, and physician progress notes, from 3/1/12 to 2/12/13, did not identify any depressive symptoms for R32, nor did was their any documented justification for the continued use of the celexa. | F 428 | | |

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| F 428 | Continued From page 23<br><br>Interview with the director of nursing (DON) on 2/15/13 at 12:00 p.m. confirmed that there was no additional information for the monitoring and continued use of R32's celexa.<br><br>Interview with the facility's consulting pharmacist on 2/15/13, at 12:30 p.m. confirmed R32's celexa had not been addressed. The pharmacist further included he had not been too focused on the antidepressant, but verified the continued use should have been addressed. | F 428 | | |
| F 465 SS=E | 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to provide housekeeping and maintenance services to maintain a sanitary and comfortable interior for 12 of 40 residents in the census sample (R42, R52, R30, R9, R5, R21, R23, R3, R34, R43, R51, and R46) related to chipped paint on resident door frames and walls, vinyl resident room bathroom floors were in poor condition, and the main tub room flooring and registers were worn and chipped.<br><br>Findings include:<br><br>During preliminary observations of resident rooms the following observations were made: | F 465 | F465<br>Safe/Functional/Sanitary/Comfortable Environment<br><br>1. The administrator and maintenance director reviewed and assessed the quality of the A. bathroom flooring, B. toilet riser, C. tub room floors and registers, D. paint on room walls, registers, and doors, and E. cleaning of toilet bowl.<br><br>2a.A. The bathroom flooring adjacent to rooms E21, W4, and W1 will be replaced within 90 days of this Plan of Corrections.<br>B. The toilet riser in room W8 has been replaced, 1 March 2013.<br>C. Floors in the rooms have been painted to prevent slipping and registers have been cleaned and painted, 1 March 2013. | |

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| F 465 | Continued From page 24<br><br>On 2/12/13 at 9:09 a.m., the vinyl bathroom flooring in a room shared by R42 and R52 (room E21), was observed to be pulling away from the wall in the corner behind the toilet, and the ceiling paint was chipped.<br><br>On 2/12/13 at 11:07 a.m., the paint on the walls and doorways in the room shared by R30 and R9 (room W9) was noted to be chipped.<br><br>On 2/12/13 at 11:28 a.m., the paint on the walls and doorframe was chipped, and the toilet riser in the bathroom was cracked and broken, and appeared dirty in R5's room (W8).<br><br>On 2/12/13 at 11:42 a.m., R21 and R23's shared room (W4) was observed to have a dirty toilet, the flooring in the bathroom was stained yellowish and there was an offensive odor. The wall paint in the room and on the doorways to the room, and to the bathroom, were chipped.<br><br>On 2/12/13 at 11:57 a.m., the wall paint and doorframe paint was chipped in the room shared by R3 and R34 (room W5).<br><br>On 2/13/13 at 9:31 a.m, the room shared by R43 and R51 (room W1), was observed to have scuffed marks on the walls, the bathroom tile around the toilet was rusted, and bedroom closet door was dented and chipped.<br><br>On 2/13/13 at 10:02 a.m., the closet door in R46's room (W15) was observed to be chipped at the bottom. In addition, the wall paint was chipped.<br><br>During the environmental tour at 10:30 a.m. on | F 465 | D. The paint on the walls and doors in rooms W9, W8, W4, W5, W1, and W15 will be painted to within 45 days of this Plan of Corrections.<br>E. The toilet bowl in W4 was cleaned the next day in accordance with housekeeping protocol to clean resident toilet rooms daily.<br><br>2b. A/B/C/D/E. The administrator or designee will do weekly room audits x1 month to assess the other rooms and monthly thereafter, reporting to the QA committee.<br><br>2c. A. Plans are in place and bids received to replace flooring in resident toilet rooms beginning 22 April 2013.<br>B. Facility will audit the quality of toilet risers monthly and purchase or repair risers as needed.<br>C. Facility will seek out and implement improved methods to prevent slipping on floors around the bathtubs.<br>D. Facility will do a monthly audit of resident rooms to ensure the room is safe, functional, sanitary and comfortable.<br>E. Resident toilets will continue to be maintained daily and as needed by housekeeping staff. | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| F 465 | Continued From page 25<br>2/13/13, with the maintenance director, the issues with resident door frames, room walls, and bathroom flooring were confirmed.<br><br>At 8:00 a.m. on 2/14/13, an additional environmental tour was conducted with the maintenance director. He acknowledged the resident doorway frames and walls had chipped paint and stated they were not scheduled to be painted until March of 2013. He also stated the resident units only get touched up twice a year or when a resident moves out. The maintenance director verified several resident rooms needed to be painted and bathrooms needed new flooring as they were stained and cracked. In addition, during this tour, it was observed that the non slip flooring adhesive in the tub rooms had worn off. The registers in the tub rooms were dirty and the paint on them was chipping. The maintenance director verified the flooring and the registers were in need of repair and stated there was currently no plan in place to make these repairs. The maintenance director was unsure whether there were any written policies in place for environmental repairs. | F 465 | 2d. A/B/C/D/E - The QA committee will review the monthly audits of resident rooms and toilet rooms monthly to ensure safe, functional, sanitary, and comfortable conditions.<br><br>2e.A. Corrective Action will be complete by ~~June 20,~~2013. 3/27/13<br><br>B. Corrective Action will be complete by March 27,2013.<br><br>C. Corrective Action will be complete by March 27, 2013.<br><br>D. Corrective Action will be complete by ~~April 29,~~ 2013. 3/27/13<br><br>E. Corrective Action will be complete by March 27,2013. | 3-27-13 |
| F 493 SS=C | 483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN<br><br>The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility | F 493 | F493 Governing Body-Facility Policies/Appoint Administrator<br><br>See attached letter. | 3-19-13 |

3/25/13 2pm Per phone conv. - Robert Johannsen, Admin will cmp POC date to 3/27/13.

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| F 493 | Continued From page 26<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure the acting administrator was appointed by the governing board. This had the potential to affect all 44 residents who currently resided in the building.<br><br>Findings include:<br><br>When the survey team entered the facility at 6:45 a.m. on 2/12/13, licensed practical nurse (LPN)-F stated they were currently without an administrator.<br><br>When interviewed at 8:15 a.m. on 2/12/13, the director of nursing (DON) stated the facility was currently without an administrator, but that they'd hired someone who was starting at the end of the month.<br><br>At approximately 8:30 a.m. on 2/12/13, the office manager approached a surveyor and stated, "they told me to tell you I'm in charge." When questioned further, the office manager did not seem to recognize that being "in charge" meant she had been appointed as the administrator.<br><br>At 8:35 a.m. on 2/12/13, the DON was informed that the office manager had informed us she was "in charge." The DON said she did not think the office manager would be put in charge of nursing.<br><br>At 8:40 a.m., on 2/12/13, the office manager and DON were interviewed together. During this discussion, the office manager confirmed the facility's parent company had appointed her as | F 493 | | |

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| F 493 | Continued From page 27<br>the person "in charge." During that discussion the administrator for the parent company was contacted by phone. She verified that the office manager would be "in charge" under her administrator's license.<br><br>Documentation of the Governing Board's appointment of the office manager to acting administrator was requested. No documentation was provided to demonstrate that the Board had appointed the office manager as the acting administrator, but a note was faxed from the parent company's administrator indicating such dated 2/12/12.<br><br>During interview with a variety of facility personnel throughout the survey, few were aware that the office manager had been appointed as the acting administrator.<br><br>No further information was provided. | F 493 | | |

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

F54360022

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

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| | 245436 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 02/15/2013 |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>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.<br><br>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.<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Parkview Care Center Inc. Wells was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES ( K-TAGS) TO:<br><br>Health Care Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145 | K 000 | POC ok w/AW for K67 FS 4-8-13 | |

DC: 03.27.2013
EXIT: 02.15.2013

RECEIVED
MAR 25 2013
DEPT OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| [signature] | Administrator | 3/22/13 |

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

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OMB NO. 0938-0391

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| K 000 | Continued From page 1<br>St Paul, MN 55101-5145, or<br><br>By email to:<br>Barbara.Lundberg@state.mn.us and<br>Marian.Whitney@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br><br>Parkview Care Center Inc. Wells is a 1-story building. The original building was constructed in 1961 and was determined to be of Type II (222) construction. In 1967, an addition was constructed and determined to be of Type II(222) construction, with a partial basement. In 1999, an addition was constructed and was determined to be of Type II(000) construction. The building will be surveyed as one building Type II (000).<br><br>The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.<br><br>The facility has a capacity of 55 beds and had a census of 46 at the time of the survey. | K 000 | | |

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245436 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 02/15/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PARKVIEW CARE CENTER WELLS INC | 55 TENTH STREET SOUTHEAST<br>WELLS, MN 56097 |

| (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 |
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| K 000 | Continued From page 2<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 067 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2<br><br>This STANDARD is not met as evidenced by:<br>Based on observations and documentation review, the facility's general ventilating and air conditioning system (HVAC) in the 1960's buildings is not installed in accordance with the 2000 NFPA 101 LSC, Section 19.5.2.1 and 1999 NFPA 90A, Sections 2-3.11 and 3-4.7. A noncompliant HVAC system could affect all 46 residents.<br><br>Findings include:<br><br>On facility tour between 10:30 AM and 12:30 PM on 02/15/2013, observation revealed, that the corridors in the 1961 and 1967 buildings are being utilized as the supply air plenum for the resident rooms. Annual waiver as been approved in previous year.<br><br>This deficient practice was confirmed by the Facility Maintenance Director (TS) at the time of | K 067 | **K67 NFPA 101 Life Safety Code Standard**<br><br>See attached waiver request. Annual Waiver | |

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|---|---|---|---|---|
| K 067 | Continued From page 3<br>discovery. | K 067 | | |

## Sheehan, Pat (DPS)

**From:** Sheehan, Pat (DPS)
**Sent:** Monday, April 08, 2013 1:21 PM
**To:** 'rochi_lsc@cms.hhs.gov'
**Cc:** Schroeder, Gary (DPS); 'pat.dallman@parkviewccwells.com'; 'Colleen Leach'; 'Jim Loveland'; 'Mark Meath'; 'Mary Henderson'; 'Shellae Dietrich'; Steege, Nicole (MDH); Whitney, Marian (DPS)
**Subject:** Parkview Care Center Wells Inc (245436) K67 Annual Waiver Request

This is to inform you that Parkview CC Wells Inc is requesting an annual waiver for K67, corridors as a plenum. The exit date was 2-15-13.

I am recommending that CMS approve this waiver request.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

| Name of Facility | 2000 CODE |
|---|---|
| Parkview Care Center | |

**PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS**

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

| PROVISION NUMBER(S) | JUSTIFICATION |
|---|---|
| K67<br><br>HVAC Equipment shall comply with Sec 9.2 and NFPA 90A. | A waiver is requested for K 67 for the following reasons:<br>A. There will be no adverse effect on the health and safety of the facilities residents and staff since:<br>a. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFPA 13.<br>b. The facility is smoke free and signs to that effect are prominently posted at all major entrances.<br>c. Annual service and maintenance contracts exist to service all the facilities fire protection systems (i.e. fire alarm, sprinkler system, and portable fire extinguishers.)<br>d. The building fire alarm system is monitored to provide automatic fire department notification.<br>e. The HVAC system automatically shuts down when the fire alarm is activated.<br>f. Fire safety training is provided for all employees on an annual basis and during orientation for all new hires.<br>g. Fire drills are conducted monthly on all shifts.<br>B. Compliance with this provision would impose an unreasonable hardship on the facility since:<br>a. Bid obtained from the Schwickert Company to fabricate and install the new supply and return ductwork through corridors is quoted at $119,438.00. This bid does not include removal, moving or re-installation of ceiling grid, electrical wiring, control wiring, plumbing piping, control wiring with suppression system, permits, signed drawings, or state plan review costs.<br>b. There is concern about whether the building electrical system is adequate to handle the additional HVAC equipment required.<br>c. The building is in compliance with all other fire safety requirements.<br>d. LSC(OO), Sec 9.2.1 gives the A.HJ authority to allow existing HVAC systems that do not comply it NFPA 90A to be continued in service. |

| Surveyor *(Signature)* | Title | Office | Date |
|---|---|---|---|
| Fire Authority Official *(Signature)* | Title: Fire Safety Supervisor | Office: State Fire Marshal | Date: 4-8-13 |

SCHWICKERT'S
TECTA AMERICA

February 19, 2013

Park View Care Center
55 10th St SE
Wells MN 56097

Attn: Tim Orbell

Re: Resident Room Ventilation Budgets 2013

Dear Tim:

Per your request Schwickert's is resubmitting our budget proposal for Resident Room Ventilation. Budget numbers are based upon current material and labor pricing.

I have reviewed the sizes of the resident rooms and the ventilation requirements for Nursing Facilities. We would need to supply each room with 70 cubic feet per minute of outside air and balance exhaust to the same. This would give you the two air changes per hour in each room and more than the ten air changes in the bathroom. The corridors also have a requirement of four air changes per hour. This modification would cause the corridors to be under aired. I have come up with the following budgets.

1. Install new supply duct on the roof and duct in a diffuser into each resident room. The budget for this would be $51,188.00.
2. Install two new makeup air handlers to meet increased ventilation in corridors. The budget for this would be $68,250.00.

**These budgets do not include permits, signed drawings or state plan review costs.**

**Sincerely,**

**Dan Shortall**

**Project Manager/Estimator**

**PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS**

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| Surveyor *(Signature)* | Title | Office | Date |
|---|---|---|---|
| Fire Authority Official *(Signature)* | Title | Office | Date |

SCHWICKERT'S®
TECTA AMERICA

February 19, 2013

Park View Care Center
55 10th St SE
Wells MN 56097

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**Sincerely,**

**Dan Shortall**

**Project Manager/Estimator**

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

Certified Mail # 7011 2000 0002 5148 9370

March 5, 2013

Ms. Jessica Raad, Administrator
Parkview Care Center Wells Inc
55 Tenth Street Southeast
Wells, Minnesota 56097

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5436022

Dear Ms. Raad:

The above facility was surveyed on February 12, 2013 through February 15, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

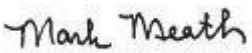
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, Mankato Place 12 Civic Center Plaza, Suite # 2105 Mankato Minnesota 56001. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Maria King at (507) 344-2716.

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.

Please feel free to call me with any questions.

Sincerely,



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

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00784 | A. BUILDING: _____ B. WING _____ | 02/15/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PARKVIEW CARE CENTER WELLS INC | 55 TENTH STREET SOUTHEAST WELLS, MN 56097 |

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On February 12, 13, 14 and 15th surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and | 2 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. | |

| 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 | Continued From page 1<br>Certification Program; 12 Civic Center Plaza, Suite 2105, Mankato, Minnesota 56001 | 2 000 | 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | |
| 21530 | MN Rule 4658.1310 A.B.C Drug Regimen Review<br><br>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.<br>B. The pharmacist must report any | 21530 | | |

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| 21530 | Continued From page 2<br>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.<br>C. If the attending physician does not concur with the pharmacist's recommendation, or does 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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the facility failed to assure the consultant pharmacist monitored medication regimens to ensure justification and monitoring were in place for the continued use of antidepressants for 2 of 10 residents (R26 and R32) reviewed for unecessary medications.<br><br>Findings include:<br><br>The consultant pharmacist failed to make any | 21530 | | |

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| 21530 | Continued From page 3 | 21530 | | |

recommendations about the continued use of Celexa 20 mg or the lack of mood monitoring for R26.

R26's medical record was reviewed. Current physician orders included a orders for Celexa (an antidepressant) 20 mg (milligrams) po (orally) QD (daily). The record indicated the resident had utilized that dosage of Celexa since March of 2012. There had been no documented physician justification for continued use, or any attempts at a dosage reduction since 5/23/12.

A physician's progress note dated 5/23/12 included, "Depression: Doing well on citalopram (generic Celexa) 20 mg daily. Will consider dose reduction in September." The physician notes were reviewed from May 2012 through February 13, 2013, and there were no further recommendations related to a dosage reduction identified.

R26's medical record also failed to indicate that any monitoring of mood/behaviors was being conducted to monitor the effectiveness of the Celexa.

The consultant pharmacist's reviews from 5/24/12-1/23/13 were reviewed. During that time frame the consultant pharmacist had not identified any irregularities for R26's drug regimen.

R32 had received celexa 20 mg daily, since prior to his admission to the facility on 10/3/08. During R32's stay at the facility, there had been no attempts at a dose reduction or documented medical justification regarding the continued use of the medication In addition, the resident's mood symptoms had not been monitored over the past

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| 21530 | Continued From page 4<br>year.<br><br>R32 had been admitted to the facility on 10/3/08 . His diagnoses included: hypothyroidism, anxiety disorder and depressive disorder. Review of the most current quarterly MDS (minimum data set) dated 9/2/11, identified R32 as having no depressive symptoms. Review of the resident's mood interview form dated 11/19/12, indicated the resident scored a "0" which identified the resident as having minimal depression, but did not identify any specific symptoms. Review of the resident's plan of care dated 6/4/12, identifies R32 as receiving a psychoactive medication related to depression. Approaches included: 1) monitor for effectiveness and possible adverse side effects of the medication. 2) review for dose reduction at least every 6 months. 3) the physician to review and address the medication.<br><br>Review of the Pharmacy consultant progress notes dated 10/22/12, did not address the continued use of the celexa, nor did it identify monitoring for the continued use.<br><br>Review of the nurses' notes, and physician progress notes, from 3/1/12 to 2/12/13, did not identify any depressive symptoms for R32, nor did was their any documented justification for the continued use of the celexa.<br><br>Interview with the director of nursing (DON) on 2/15/13 at 12:00 p.m. confirmed that there was no additional information for the monitoring and continued use of R32's celexa.<br><br>Interview with the facility's consulting pharmacist on 2/15/13, at 12:30 p.m. confirmed R32's celexa had not been addressed. The pharmacist further included he had not been too focused on the | 21530 | | |

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| 21530 | Continued From page 5<br>antidepressant, but verified the continued use should have been addressed.<br><br>SUGGESTED METHOD FOR CORRECTION: The administrator, director of nursing and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Staff could be educated as necessary. The director of nursing or designee could monitor medications on a regular basis to ensure compliance with State and federal regulations.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21530 | | |
| 21535 | MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General<br><br>Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:<br>A. in excessive dose, including duplicate drug therapy;<br>B. for excessive duration;<br>C. without adequate indications for its use; or<br>D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued.<br>In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan | 21535 | | |

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| 21535 | Continued From page 6<br>system and the State Law Library. It is not subject to frequent change.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to adequately monitor and assess clinical indications for continued use of an antidepressant for 2 of 10 residents (R26 and R32) in the sample, who were reviewed for unnecessary medication usage.<br><br>The findings include:<br><br>R26's medical record was reviewed. Current physician orders included a prescription for Celexa (an antidepressant) 20 mg (milligrams) po (orally) QD (daily). The record indicated the resident had utilized that dosage of Celexa since March of 2012. There was no documented physician justification for continued use, or any attempts at a dosage reduction since 5/23/12.<br><br>A note to the resident's physician dated 3/26/12, by RN-E included: "Please review medications. Was receiving 10 mg Celexa prior to recent hospitalization, and still is, although discharge med (medication) list says 20 mg. Now seems more depressed. Depression scale is 2." This note had not been signed by the physician.<br><br>A physician's progress note dated 5/23/12 included, "Depression: Doing well on citalopram (generic Celexa) 20 mg daily. Will consider dose reduction in September." The physician notes were reviewed from May 2012 through February 13, 2013, and there were no further recommendations related to a dosage reduction identified. | 21535 | | |

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| 21535 | Continued From page 7<br><br>R26's medical record also failed to indicate that any monitoring of mood/behaviors was being conducted to monitor the effectiveness of the Celexa.<br><br>When interviewed on 2/14/13 at 10:00 a.m., the director of nursing offered no further information about R26's continued Celexa usage.<br><br>R32 had received the same dose of celexa (an antidepressant medication) 20 mg (milligrams) daily, since prior to his admission to the facility on 10/3/08, without an attempt for a dose reduction or documented medical justification regarding the continued use of the medication In addition, the residents mood symptoms had not been monitored or the past year.<br><br>R32 had been admitted to the facility on 10/3/08 . His diagnoses included: hypothyroidism, anxiety disorder and depressive disorder. Review of the most current quarterly MDS (minimum data set) dated 9/2/11, identified R32 as having no depressive symptoms. Review of the residents mood interview form dated 11/19/12, indicated the resident scored a "0" of which identified the resident as having minimal depression, but did not identify any specific symptoms. Review of the plan of care dated 6/4/12, identifies R32 as receiving a psychotropic medication related to depression. Approaches included; 1)monitor for effectiveness and possible adverse side effects of the medication. 2) review a dose reduction at least every 6 months. 3) the physician to review and address the medication.<br><br>Review of the Pharmacy consultant progress note dated 10/22/12, did not address the continued use of the celexa, nor did it identify monitoring for | 21535 | | |

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| 21535 | Continued From page 8<br>the continued use.<br><br>Review of the nurses notes and physician progress notes from 3/1/12 to 2/12/12, did not identify any depressive symptoms for R32, nor did it include justification for the continued use of the medication.<br><br>Interview with the director of nursing (DON) on 2/15/13 at 12:00 p.m. confirmed that there was no additional information for the monitoring and continued use of R32's celexa.<br><br>SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could review the use of psychoactive medications with the licensed staff including the State and Federal regulations. The Director of Nursing or designee could identify all residents who receive psychoactive medications and assure that they have parameters developed, target behaviors identified, and behavior monitoring, for use of these medications.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21535 | | |
| 21695 | MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance<br><br>Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the facility | 21695 | | |

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| 21695 | Continued From page 9<br><br>failed to provide housekeeping and maintenance services to maintain a sanitary and comfortable interior for 12 of 40 residents in the census sample (R42, R52, R30, R9, R5, R21, R23, R3, R34, R43, R51, and R46) related to chipped paint on resident door frames and walls, vinyl resident room bathroom floors were in poor condition, and the main tub room flooring and registers were worn and chipped.<br><br>Findings include:<br><br>During preliminary observations of resident rooms the following observations were made:<br><br>On 2/12/13 at 9:09 a.m., the vinyl bathroom flooring in a room shared by R42 and R52 (room E21), was observed to be pulling away from the wall in the corner behind the toilet, and the ceiling paint was chipped.<br><br>On 2/12/13 at 11:07 a.m., the paint on the walls and doorways in the room shared by R30 and R9 (room W9) was noted to be chipped.<br><br>On 2/12/13 at 11:28 a.m., the paint on the walls and doorframe was chipped, and the toilet riser in the bathroom was cracked and broken, and appeared dirty in R5's room (W8).<br><br>On 2/12/13 at 11:42 a.m., R21 and R23's shared room (W4) was observed to have a dirty toilet, the flooring in the bathroom was stained yellowish and there was an offensive odor. The wall paint in the room and on the doorways to the room, and to the bathroom, were chipped.<br><br>On 2/12/13 at 11:57 a.m., the wall paint and doorframe paint was chipped in the room shared by R3 and R34 (room W5). | 21695 | | |

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| 21695 | Continued From page 10<br><br>On 2/13/13 at 9:31 a.m, the room shared by R43 and R51 (room W1), was observed to have scuffed marks on the walls, the bathroom tile around the toilet was rusted, and bedroom closet door was dented and chipped.<br><br>On 2/13/13 at 10:02 a.m., the closet door in R46's room (W15) was observed to be chipped at the bottom. In addition, the wall paint was chipped.<br><br>During the environmental tour at 10:30 a.m. on 2/13/13, with the maintenance director, the issues with resident door frames, room walls, and bathroom flooring were confirmed.<br><br>At 8:00 a.m. on 2/14/13, an additional environmental tour was conducted with the maintenance director. He acknowledged the resident doorway frames and walls had chipped paint and stated they were not scheduled to be painted until March of 2013. He also stated the resident units only get touched up twice a year or when a resident moves out. The maintenance director verified several resident rooms needed to be painted and bathrooms needed new flooring as they were stained and cracked. In addition, during this tour, it was observed that the non slip flooring adhesive in the tub rooms had worn off. The registers in the tub rooms were dirty and the paint on them was chipping. The maintenance director verified the flooring and the registers were in need of repair and stated there was currently no plan in place to make these repairs. The maintenance director was unsure whether there were any written policies in place for environmental repairs.<br><br>SUGGESTED METHOD FOR CORRECTION: The Administrator and Maintenece Director could | 21695 | | |

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| 21695 | Continued From page 11<br>monitor to assure the facility is clean, and well maintanined.<br><br>TIME PERIOD FOR CORRECTION: Twenty one (21) days. | 21695 | | |
| 21800 | MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. | 21800 | | |

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| 21800 | Continued From page 12<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to provide the required Medicare (MC) denial notices for 3 of 3 residents (R25, R11, R69) discharged from MC services.<br><br>Findings include:<br><br>Three residents who were given MC denial notices, received only the expedited notice for discharge from MC services without reciept of a detailed notice to describe the specific reasons for their discharge from MC, and without ensuring the residents had been informed of their rights to request a demand bill be submitted.<br><br>R25 had been given an expedited notice of noncoverage for MC on 8/30/12. The expedited notice indicated that MC would probably not pay for her current skilled nursing services after 8/30/12. R25 was not given the detailed notice notifying her of the right to request a demand bill.<br><br>R11 had been given an expedited notice of noncoverage for MC on 11/7/12. The expedited notice indicated that MC would probably not pay for her current skilled nursing services after 11/7/12. R11 had been utilizing MC coverage due to her need for skilled physical therapy. The resident was not given a detailed notice notifying her of the right to request a demand bill.<br><br>R69 had been given an expedited notice of noncoverage for MC on 11/29/12. The expedited notice indicated that MC would probably not pay for his current skilled nursing services after 11/29/12. R69 was not given a detailed notice notifying him of his right to request a demand bill. | 21800 | | |

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| 21800 | Continued From page 13<br><br>On 2/13/12 at 11:30 a.m., registered nurse (RN) -C, responsible for giving residents their MC denial notices, was interviewed. She stated she was not aware that she had to give both the detailed notice and the expedited notices of noncoverage for MC to residents. RN-C confirmed that each of these residents had been given denials due to either goals met or lack of progress, and that each of these residents was otherwise paying privately for their stay at the nursing home.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator or designee could educate designated staff members on the appropriate process for Medicare liability and appeal notice.The administrator or designee could develop monitoring systems to ensure ongoing compliance with the Medicare denial process.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21800 | | |
| 21980 | MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults<br><br>Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: | 21980 | | |

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| 21980 | Continued From page 14<br>(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or<br>(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).<br>(b) A person not required to report under the provisions of this section may voluntarily report as described above.<br>(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.<br>(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.<br>(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure they reported | 21980 | | |

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| 21980 | Continued From page 15<br>incidents of unknown origin in a timely manner to the administrator and State agency for 5 of 5 allegations reviewed (R7, R77, R42, R10 ). They also failed to ensure they conducted a comprehensive investigation for 1 of 2 incidents of unknown origin (R10 ).<br><br>The following allegations were provided by the social worker:<br><br>1) An allegation of theft of property had been reported to the social worker on 5/18/12. According to the report, on 5/17/12, R7 and R77 had reported to the nurse that their wallets were missing. These reports were not forwarded to the social worker until 5/18/12. Although law enforcement was notified on 5/18/12, the social worker had not submitted a report to MDH until 5/22/12.<br><br>2) An allegation of alleged elopement had been reported to the social worker on 8/20/12. According to the report, on 8/20/12, R42 had left the facility grounds without notifying any staff. When staff noticed he was missing at 2:30 p.m. they had done a search of the grounds and had been unable to locate the resident. The report indicated the resident had ultimately been found a short time later alone, in his personal home. Although elopement interventions were implemented upon the resident's return to the facility, no report had been submitted to MDH until 8/21/12.<br><br>During additional information with the DON on 2/14/13 at 10:30 a.m., she stated she did not always immediately report allegations but tried to determine the cause first. When asked to review the system for determining what to report, the DON said she didn't keep a specific file for that, | 21980 | | |

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| 21980 | Continued From page 16<br><br>but would review her QA (quality assurance) data related to incidents. The DON also stated that they'd been told they were over reporting, by their common entry point contact, and that she'd been trying to determine the cause of any bruises of unknown origin prior to reporting so that they wouldn't report things they had identified likely causes for.<br><br>R10 was observed to have extensive bruising bilaterally on her arms, hands and lower outer legs that were of unknown origin. However, the facility had not reported the bruising, nor conducted an investigation to determine the potential cause of the bruising.<br><br>During observations made of R10 skin on 2/14/13 at 2:25 p.m., with nursing assistant (NA)-A, NA-B, and licensed practical nurse (LPN)-A, LPN-A measured the bruises on R10's hands, arms and outer legs. The following measurements were identified:<br><br>1) Top of right and left hand, 7.0 cm (centimeters) by 6.0 cm and dark purplish in color.<br>2) Top of both wrists, 6.0 cm by 4.0 cm and dark purplish in color.<br>3) Outer aspect of right upper arm, 6.0 cm by 5.0 cm and reddish/purple in color.<br>4) Outer aspect of upper left arm, 6.0 cm by 5.0 cm and dark purplish in color.<br>5) Outer aspect of the left mid arm near elbow, 2.0 cm by 1.0 cm and dark purplish in color.<br>6) Outer aspect of right lower leg near the knee, 3.0 cm by 4.0 cm and dark purplish in color.<br>7) Outer aspect of right lower leg near the ankle, 3.0 cm by 7.0 cm and dark purplish in color.<br>8) Outer aspect of the left lower leg near the knee, 7.0 cm by 5.5 cm and dark purplish in color. | 21980 | | |

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| 21980 | Continued From page 17<br><br>9) Outer aspect of left lower leg calf area, 8.0 cm by 5.5 cm and dark purplish in color.<br>10) Outer aspect of the left lower leg near the ankle, 6.0 cm by 4.0 cm and dark purplish in color.<br><br>During the observation, NA-A and NA-B both indicated R10 had experienced reoccurring bruising for several months. However they stated they were unsure of the causal factors of the bruising. They also stated the bruises on the residents legs could be from her bumping them on the wheelchair leg rests. NA-A and B, both indicated R10 should have arm protectors on her arms as well.<br><br>Interview with LPN-A on 2/14/13 at 2:30 p.m. indicated she was aware of the bruises on R10's body and that the resident's bruises continued to reoccur over a period of time. LPN-A was not sure when the resident's current bruises had been identified, but verified that they looked new. LPN-A included she was uncertain of the causal factors of the residents current bruises and could not inform the surveyor if the bruising was improving. She indicated leg protectors had been applied to R10's legs to protect her from bumping them on her wheelchair leg rests, but confirmed that the resident continues to bruise even with the protectors on. LPN-A further indicated R10 should have arm protectors on as well.<br><br>Observation on 2/14/13 at 2: 45 p.m. and on 2/15/13 at 10:00 a.m., R10 was laying in bed on her right side. The resident did not have the arm protectors on even though LPN-A and NA-A and B indicated the resident should have them on for protection. During observation it was also observed that the siderails were not padded per the plan of care. | 21980 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 21980 | Continued From page 18<br><br>Review of the plan of care for R10, identified the resident as having problems with skin breakdown due to poor skin integrity. It further included the resident has fragile skin and bruises and tears easily. Approaches: 1) observe with cares for prolonged areas of redness, blisters, rash and pain. 2) geri leg protectors on legs for protection when out of bed. 3) pad siderails with sheepskin. 4) do not pull or grab residents arms when turning in bed and assist by using her shoulder, hip and buttock area to turn her.<br><br>Review of the skin treatment measurement form dated 1/1/13, identified R10 with a hematoma on the lower right arm, that measured 12 cm in size, purplish in color and swollen. There was no documentation if the bruising had resolved. No other bruises were identified on the form.<br><br>Review of the incident report and nurse's note dated 1/10/13, indicated R10 had been observed to have a bruise/hematoma on the left arm when staff were assisting her to get up that morning. Documentation indicated the area had measured 12 cm in diameter. The note further indicated the staff were uncertain of the causal factor, but thought it might have been caused from repositioning. The note further indicated that staff were unable to determine any new interventions, but would continue the current interventions of not using the resident's arms with turning. No other documentation regarding R10's current bruises on her legs, hands and arms were found.<br><br>Interview with the DON on 2/15/13 at 9:30 a.m., confirmed that an investigation had not been completed in regards to the casual factors of R10's extensive bruising and that no report had been made to MDH. The DON further included | 21980 | | |

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| 21980 | Continued From page 19<br>she thought the staff had been monitoring the bruising, and stated she thought maybe the EZ stand (mechanical lift) was the cause of the bruising to the resident's arms, but could not be certain. The DON stated R10 had been using the Hoyer lift (another type of mechanical lift) for the past couple of weeks, but that the bruising had persisted. The DON stated there had been discussion with the staff in the past to use arm protectors on R10's arms, but confirmed this had not been implemented. She further included that the weekly shower sheets were to be filled out and turned into her for further investigation, but verified the staff might not fill them out each week since the bruising was reoccurring.<br><br>The facility's Vulnerable Adult policy last revised 2/2011, was reviewed on 2/14/13. The policy included directions for protection and reporting: "All staff members are mandated to report when: ...3) A resident has an unexplained injury." Definitions attached to the policy included: "Injuries of Unknown Source- An injury should be classified as an injury of unknown source when both of the following conditions are met: 1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident: and 2) The injury is suspicious because of the extent of the injury or the location of the injury...or the number of injuries observed at one particular point in time or the incidence of injuries over time."<br><br>SUGGESTED METHOD FOR CORRECTION: The administrator, DON, and social services or designee(s) could review and revise the policies and procedures regarding the process of reporting/investigating allegations of abuse/neglect. The administrator, DON, social services or designee (s) could provide training for | 21980 | | |

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| 21980 | Continued From page 20<br>all appropriate staff on these policies and procedures. The administrator, DON, social services or designee (s) could monitor to assure all reports of abuse are being reported and investigated in a timely manner.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21980 | | |
| 21995 | MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults<br><br>Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to develop and implement appropriate policies for the immediate reporting of abuse, neglect and mistreatment to the facility administrator and State agency for 5 of 5 resident incidents (R7, R77, R42, R8 and R10) reviewed in the sample for abuse prohibition. This deficient practice had the potential to affect 44 of 44 residents currently residing in the facility, and resulted in substandard quality of care.<br><br>Findings include:<br><br>The facility's Vulnerable Adult policy last revised | 21995 | | |

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| 21995 | Continued From page 21<br><br>2/2011, was reviewed on 2/14/13. The policy indicated timelines for reporting to include: "After protecting the resident(s), immediately report the situation to the supervisor and Administrator. This will start the investigation. If it is determined that a report is to be made to the Common Entry Point (CEP) and the State Electronic notification website, do so as soon as possible, no longer than 24 hours from the time of initial knowledge that the incident occurred..." The directions for investigating and follow up for allegations included: "When the Administrator, or designee, is notified of the incident, they will review the act and the information collected through interview and documentation. They will clarify the information and determine if all information has been collected. If they determine the incident requires reporting, they will confirm if the report has been made. If not, they will complete the CEP form, contact the in-take worker and submit the form. In addition, if the State on-line report has not been completed, the Administrator, or designee, will complete this process. There may be times when the report is not required to go to the CEP but is reportable to the website (such as physical or verbal abuse between residents)..." The policy also included these additional directions for minimizing the risk of abuse: "The facility designated reporter will report incidents to MDH (Minnesota Department of Health) via a secure web site. This is a two step process, initially reporting the incident and then submitting an investigative report. The initial report must be made by electronic submission to the MDH and also to the CEP immediately, meaning as soon as possible but not more than 24 hours after the discovery of the incident." The facility's policy also included directions for protection and reporting: "All staff members are mandated to report when: ...3) A resident has an unexplained | 21995 | | |

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| 21995 | Continued From page 22<br><br>injury." Definitions attached to the policy included: "Injuries of Unknown Source- An injury should be classified as an injury of unknown source when both of the following conditions are met: 1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident: and 2) The injury is suspicious because of the extent of the injury or the location of the injury...or the number of injuries observed at one particular point in time or the incidence of injuries over time."<br><br>During interview with the facility's director of nursing (DON) on 2/14/13 at 9:45 a.m., the DON stated staff were supposed to immediately report allegations of abuse to her and that she'd then report to the administrator. When asked to review reports, the DON directed the surveyor to the social worker.<br><br>Allegations of abuse/neglect were requested for review from the facility's social worker on 2/14/13 at 10:00 a.m. The social worker stated at that time that she had only reported two incidents in the past year. She said she did not keep any files of allegations they had decided not to report, and referred the surveyor to the DON. In addition, the social worker stated she did not always submit the report to MDH immediately. She stated she had understood they had up to 24 hours to report allegations.<br><br>The following allegations were provided by the social worker:<br><br>1) An allegation of theft of property had been reported to the social worker on 5/18/12. According to the report, on 5/17/12, R7 and R77 had reported to the nurse that their wallets were | 21995 | | |

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| 21995 | Continued From page 23<br><br>missing. These reports were not forwarded to the social worker until 5/18/12. Although law enforcement was notified on 5/18/12, the social worker had not submitted a report to MDH until 5/22/12.<br><br>2) An allegation of alleged elopement had been reported to the social worker on 8/20/12. According to the report, on 8/20/12, R42 had left the facility grounds without notifying any staff. When staff noticed he was missing at 2:30 p.m. they had done a search of the grounds and had been unable to locate the resident. The report indicated the resident had ultimately been found a short time later alone, in his personal home. Although elopement interventions were implemented upon the resident's return to the facility, no report had been submitted to MDH until 8/21/12.<br><br>During additional information with the DON on 2/14/13 at 10:30 a.m., she stated she did not always immediately report allegations but tried to determine the cause first. When asked to review the system for determining what to report, the DON said she didn't keep a specific file for that, but would review her QA (quality assurance) data related to incidents. The DON also stated that they'd been told they were over reporting by their common entry point contact, and that she'd been trying to determine the cause of any bruises of unknown origin prior to reporting so that they wouldn't report things they had identified likely causes for.<br><br>R10 was observed to have extensive bruising bilaterally on her arms, hands and lower outer legs on 2/14/13 at 2:25 p.m. Interviews with staff, and record review, revealed the staff were unaware of the origin of the bruising. However, | 21995 | | |

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| 21995 | Continued From page 24 | 21995 | | |

the facility had not reported the bruising, nor conducted an investigation to determine the potential cause of the bruising. The bruising had been measured during the observation:
1) Top of right and left hand, 7.0 cm (centimeters) by 6.0 cm and dark purplish in color.
2) Top of both wrists, 6.0 cm by 4.0 cm and dark purplish in color.
3) Outer aspect of right upper arm, 6.0 cm by 5.0 cm and reddish/purple in color.
4) Outer aspect of upper left arm, 6.0 cm by 5.0 cm and dark purplish in color.
5) Outer aspect of the left mid arm near elbow, 2.0 cm by 1.0 cm and dark purplish in color.
6) Outer aspect of right lower leg near the knee, 3.0 cm by 4.0 cm and dark purplish in color.
7) Outer aspect of right lower leg near the ankle, 3.0 cm by 7.0 cm and dark purplish in color.
8) Outer aspect of the left lower leg near the knee, 7.0 cm by 5.5 cm and dark purplish in color.
9) Outer aspect of left lower leg calf area, 8.0 cm by 5.5 cm and dark purplish in color.
10) Outer aspect of the left lower leg near the ankle, 6.0 cm by 4.0 cm and dark purplish in color.

During the observation, NA-A and NA-B both indicated R10 had experienced reoccurring bruising for several months. However they stated they were unsure of the causal factors of the bruising.

Interview with LPN-A on 2/14/13 at 2:30 p.m. indicated she was aware of the bruises on R10's body and that the resident's bruises continued to reoccur over a period of time. LPN-A was not sure when the resident's current bruises had been identified, but verified that they looked new. LPN-A included she was uncertain of the causal

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| 21995 | Continued From page 25<br><br>factors of the residents current bruises and could not inform the surveyor if the bruising was improving.<br><br>During interviews with staff regarding reporting, registered nurse (RN)-A stated at 3:18 p.m. on 2/14/13, that she wouldn't report a large bruise of unknown origin to anyone, but would try to investigate first, would make out an incident report and would notifiy the physician.<br><br>LPN-D stated at 3:25 on 2/14/13, that she would make out an incident report and initiate monitoring sheets, but would not otherwise report.<br><br>During additional interview with the social worker at 3:28 p.m. on 2/14/13, she reiterated she would report to the DON. She also stated she was not aware that the language in their facility policy was wrong, and stated, "that's probably because we don't have an administrator right now."<br><br>Interview with the DON on 2/15/13 at 9:30 a.m., confirmed that an investigation had not been completed in regards to the casual factors of R10's extensive bruising, and that the bruising had not been reported to MDH.<br><br>SUGGESTED METHOD FOR CORRECTION: The administrator, DON, social services or designee(s) could review and revise as necessary the policies and procedures regarding the internal process of reporting/investigating the process of abuse or maltreatment. The administrator, DON, social services or designee (s) could provide training for all appropriate staff on these policies and procedures. The administrator, DON, social services or designee (s) could monitor to assure all reports of abuse | 21995 | | |

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| 21995 | Continued From page 26<br>are being reported and investigated.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21995 | | |