### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: SG3J Facility ID: 00754

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245509  2.STATE VENDOR OR MEDICAID NO. (L2) 015540300  5. EFFECTIVE DATE CHANGE OF OWNERSHIP	3. NAME AND ADDRESS OF FA (L3) ADAMS HEALTH CARI (L4) 810 WEST MAIN STREI (L5) ADAMS, MN 7. PROVIDER/SUPPLIER CATE	E CENTER ET	(L6) <b>55909</b>	4. TYPE OF ACTION: 7 (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other			
(L9) 6. DATE OF SURVEY 10/19/2015 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	01 Hospital 05 HHA 02 SNF/NF/Dual 06 PRTF 03 SNF/NF/Distinct 07 X-Ray 04 SNF 08 OPT/SP	09 ESRD 10 NF 11 ICF/IID 12 RHC	13 PTIP 22 CLIA 14 CORF 0 15 ASC 16 HOSPICE	8. Full Survey After Complaint  FISCAL YEAR ENDING DATE: (L35)  09/30			
11LTC PERIOD OF CERTIFICATION  From (a):  To (b):  12.Total Facility Beds	10.THE FACILITY IS CERTIFIED  X A. In Compliance With  Program Requirements  Compliance Based On:	ogram	And/Or Approved Waivers Of 7  2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code  * Code: A	6. Scope of Services Limit 7. Medical Director			
14. LTC CERTIFIED BED BREAKDOWN  18 SNF 18/19 SNF 19 SNF  49 (L37) (L38) (L39)  16. STATE SURVEY AGENCY REMARKS (IF APPLICA	ICF IID (L42) (L43) BLE SHOW LTC CANCELLATION	)	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)			
19. DETERMINATION OF ELIGIBILITY  1. Facility is Eligible to Participate  2. Facility is not Eligible	Date:  11/02/2015  COMPLETED BY HCFA R  20. COMPLIANCE WT RIGHTS ACT:	REGIONAI	18. STATE SURVEY AGENCY APPROVAL Date:  Kamala Fiske-Downing, Enforcement Specialist 11/04/2015 (L20  AL OFFICE OR SINGLE STATE AGENCY  21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above:				
(1.27)	DATE ENDING D (L25)		26. TERMINATION ACTION:  VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	05-Fail to Meet Health/Safety ment 06-Fail to Meet Agreement			
(L28)	. INTERMEDIARY/CARRIER NO 03001 . DETERMINATION OF APPROVA	(L31)	30. REMARKS  DETERMINATION APPR	ROVAL			



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245509

November 2, 2015

Mr. Donald Flack III, Administrator Adams Health Care Center 810 West Main Street Adams, MN 55909

Dear Mr. Flack III:

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

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

Effective October 5, 2015 the above facility is certified for:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske. Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered November 2, 2015

Mr. Donald Flack III, Administrator Adams Health Care Center 810 West Main Street Adams, Minnesota 55909

RE: Project Number S5509024

Dear Mr. Flack III:

On September 17, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 3, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 19, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 24, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 3, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 5, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 3, 2015, effective October 5, 2015 and therefore remedies outlined in our letter to you dated September 17, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Riske. Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

### Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245509	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 10/19/2015
Nam	e of Facility		Street Address, City, State, Zip Code	
Al	DAMS HEALTH CARE CENTER		810 WEST MAIN STREET	

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
	F0241 483.15(a)		Correction Completed 09/24/2015		F0247 483.15(e)(2)		Correction Completed 09/24/2015			F0282 483.20(k)(3)(ii		Correction Completed 09/24/2015
	F0314 483.25(c)		Correction Completed 09/24/2015	ID Prefix Reg. # LSC	F0315 483.25(d)		Correction Completed 09/24/2015			F0323 483.25(h)		Correction Completed 09/24/2015
ID Prefix Reg. # LSC	483.25(I)		Correction Completed 09/24/2015	ID Prefix Reg. # LSC	F0428 483.60(c)		Correction Completed 09/18/2015			F0431 483.60(b), (d),		Correction Completed 09/24/2015
ID Prefix Reg. # LSC	F0465 483.70(h)		Correction Completed 09/24/2015	Reg. #								
ID Prefix			Correction Completed	ID Prefix Reg. # LSC					<b>.</b> "			
Reviewed E	3v	Reviewed	By	Date:	Signatur	o of Sur	vovor:				Date:	
		GPN/kfd	-		Signature	e or Sur	•	160				10/10/2015
State Agen Reviewed E CMS RO	Зу			11/04/201 Date:	Signature	e of Sur		100			Date:	10/19/2015
Followup t	o Survey Co 9/3/	ompleted on 2015	:			•				Summary of the Facility?	YES	NO

### Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245509	( <b>Y2) Multiple Con</b> A. Building B. Wing	IN BUILDING 01	(Y3) Date of Revisit 10/24/2015
Name of Facility		Street Address, City, State, Zip Code	
ADAMS HEALTH CARE CENTER		810 WEST MAIN STREET ADAMS MN 55909	

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) [	ate	(Y4) Item		(Y5)	Date	(Y4)	Item	(Y	<b>′</b> 5)	Date
			ection				Correction					Correction
ID Prefix			npleted 5/2015	ID Prefix			Completed <b>09/24/2015</b>		ID Prefix			Completed
	NFPA 101				NFPA 101							<del></del>
LSC	K0054			LSC	K0144				LSC	_		
		Con	ection				Correction					Correction
			npleted				Completed					Completed
ID Prefix			.,	ID Prefix					ID Prefix			
Reg. #				Reg. #					Reg. #			
LSC				LSC					LSC			
		Cori	ection				Correction					Correction
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												<u> </u>
Reg. #				Reg. #					Reg. #			
				200								<u> </u>
		Cori	ection				Correction					Correction
ID Prefix			npleted	ID Prefix			Completed		ID Profix			Completed
				Reg. #					Reg. #			<del>_</del>
Reg. # LSC				LSC					LSC			<u> </u>
		0					0					
			ection apleted				Correction Completed					Correction Completed
ID Prefix			ipiotod	ID Prefix			Completed		ID Prefix			
Reg. #				Reg. #					Reg. #			
LSC				LSC					LSC			
Reviewed I	By Re	viewed By		Date:	Signature	of Sur	veyor:			1	Date:	
State Agen	cy TI	/kfd		11/02/20	15		2	2582	2		1	0/24/2015
Reviewed I	Ву Re	viewed By		Date:	Signature	of Sur	veyor:			Ţ	Date:	
CMS RO												
Followup t	to Survey Compl				Check for an	y Uncor	rected Defic	cienci	es. Was a	Summary of		
	9/2/201	5			Uncorrecte	eu Deilc	iencies (CIV	13-25	or) Sent to	the Facility?	YES	NO

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

KE & MEDICA	ID SERVICES
ID:	SG3J
Fac	ility ID: 00754
TYPE OF ACTION:	<b>2</b> (L8)
<ol> <li>Initial</li> <li>Termination</li> <li>Validation</li> <li>On-Site Visit</li> </ol>	<ol> <li>Recertification</li> <li>CHOW</li> <li>Complaint</li> <li>Other</li> </ol>
8. Full Survey After Co	omplaint
CAL YEAR ENDING	DATE: (L35)
09/30	
ollowing Requirement  6. Scope of Servic  7. Medical Direct  8. Patient Room S	ces Limit or

1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. (L3) ADAMS HEALTH CARE CENTER (L1)245509 (L4) 810 WEST MAIN STREET 2.STATE VENDOR OR MEDICAID NO. (L6) 55909 015540300 (L2)(L5) ADAMS, MN 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 (L7) (L9) 05 HHA 13 PTIP 01 Hospital 09 ESRD 22 CLIA 6. DATE OF SURVEY 09/03/2015 (L34) 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF FIS 8. ACCREDITATION STATUS: \_\_ (L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 12 RHC 16 HOSPICE 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 2 AOA 3 Other 11. .LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: And/Or Approved Waivers Of The Fo A. In Compliance With From (a): Program Requirements 2. Technical Personnel To (b): Compliance Based On: 3. 24 Hour RN 12. Total Facility Beds 4. 7-Day RN (Rural SNF) (L18) \_1. Acceptable POC 49 5. Life Safety Code 9. Beds/Room X B. Not in Compliance with Program **49** (L17) 13. Total Certified Beds Requirements and/or Applied Waivers: \* Code: **R**\* (L12)15. FACILITY MEETS 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): (L15)49 (L38) (L37) (L39) (L42)(L43) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE Date: 18. STATE SURVEY AGENCY APPROVAL Kamala Fiske-Downing, Enforcement Specialist 10/09/2015 (L20) 09/262015 Austin Fry, HFE NE II (L19) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) RIGHTS ACT: 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) Facility is Eligible to Participate 3. Both of the Above: 2. Facility is not Eligible (L21)

22. ORIGINAL DATE	23. LTC AGREEMENT	24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING DATE	ENDING DATE	VOLUNTARY 00	INVOLUNTARY
01/01/1988			01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)	(L25)	02-Dissatisfaction W/ Reimbursement	06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVE SANCTIO		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change
(L27)	A. Suspension of Admission     B. Rescind Suspension Date	(L44)		00-Active
	·	(L45)		
28. TERMINATION DATE:	29. INTERMEI	DIARY/CARRIER NO.	30. REMARKS	
	03001			
	(L28)	(L31)		
31. RO RECEIPT OF CMS-1539	32. DETERMIN	NATION OF APPROVAL DATE	-	
	(L32)	(L33)	DETERMINATION APPROVA	L



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered September 17, 2015

Mr. Donald Flack III, Administrator Adams Health Care Center 810 West Main Street Adams, Minnesota 55909

RE: Project Number S5509024

Dear Mr. Flack III:

On September 3, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

#### DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904 gary.nederhoff@state.mn.us

Telephone: (507) 206-2731 Fax: (507) 206-2711

#### **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 October 13, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 13, 2015 the following remedy will be imposed:

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

### ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

Adams Health Care Center September 17, 2015 Page 4

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

### Original deficiencies not corrected

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

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

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

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

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

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

If substantial compliance with the regulations is not verified by December 3, 2015 (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

Adams Health Care Center September 17, 2015 Page 5

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 March 3, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

### INFORMAL DISPUTE RESOLUTION

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

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

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

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

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. Gary Schroeder, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 gary.schroeder@state.mn.us

Telephone: (507) 361-6204

Adams Health Care Center September 17, 2015 Page 6

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kamala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

PRINTED: 09/26/2015 FORM APPROVED OMB NO. 0938-0391

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG	(X3) DATE COMF	SURVEY
		245509	B. WING _	<del></del>	09/0	3/2015
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDENCY)	D BE	(X5) COMPLETION DATE
F 000 F 241 SS=D	as your allegation of Department's accelenrolled in ePOC, yat the bottom of the form. Your electror be used as verificated Upon receipt of an on-site revisit of you validate that substate regulations has been your verification. 483.15(a) DIGNITY INDIVIDUALITY  The facility must present acceleration of the property of	of correction (POC) will serve of compliance upon the otance. Because you are our signature is not required a first page of the CMS-2567 nic submission of the POC will cion of compliance.  Cacceptable electronic POC, an our facility may be conducted to ential compliance with the en attained in accordance with a CAND RESPECT OF	F 00			9/24/15
	enhances each res full recognition of h  This REQUIREMEI by: Based on observat review, the facility f (R15) observed durassistance was treaphysical cares and Findings include: R15's Physician Or diagnoses that incluosteoporosis. The indicated R15 was	environment that maintains or ident's dignity and respect in is or her individuality.  NT is not met as evidenced alled to ensure 1 of 1 residenting activities of daily living ated in a dignified manner with verbal conversation.  der Report indicated R15 had added dementia and Physician Order Report also on acetaminophen (analgesic) amadol (analgesic) three times		R15 is treated in a dignified manner physical cares and verbal communall residents of Adams Health Carenter will be treated in a dignified manner with physical cares and vecommunication.  Nursing staff in-serviced on resperinteraction with residents on September 24, 2015.  DON and/or her designee will more daily for a week, once per week for weeks and once per month for 3 results will be reviewed by QA/QI	nication. e d derbal ctful ember nitor or 2 nonths.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/25/2015

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

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	2) MULTIPLE CONSTRUCTION (X3) BUILDING			(3) DATE SURVEY COMPLETED	
		245509	B. WING			09/	03/2015	
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, 810 WEST MAIN S ADAMS, MN 55	_	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CC	DER'S PLAN OF CORRECTIC DRRECTIVE ACTION SHOUL FERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 241	remission. R15's Minimum Data Set indicated R15 had R15's Cognitive Loc directed staff to provindependent decisic clothes to wear." F (ADL) Functional R plan indicated that related to generaliz to perform ADLs indirected staff to phywith grooming/hygiweekly bath.  On 9/2/15, at 9:14 a closet, near her dogarment. Nursing Mand, in a sharp tone want to put on a ho NA-D pulled the pir and stated to R15, over 80 outside!" N times during the int was talking, she put top. NA-D then lifted quickly thrust R15's immediately said, "working here?"  In an interview on Stated that she is domobility staff, and go twice a month (this help residents with the job.	ng to multiple myeloma, in Admission assessment (MDS), dated 6/17/15 severely impaired cognition. ss/Dementia Care Plan ovide opportunities of on making, "i.e. choosing 15's Activities of Daily Living ehabilitation Potential Care R15 had a self-care deficient ed weakness and was unable dependently. R15's care plan ysically assist R15 one-on-one ene, dressing, toileting and a.m., R15 was in front of her orway, pointing to a pink Assistant (NA)-D approached e of voice, told R15 she didn't usecoat, it was after breakfast. In garment out of the closet "Oh, it's a sweater. But it's A-D referred to R15 several eraction as "Hun." As NA-D at R15's right arm into the pink ed R15's left arm up and arm into the sleeve. R15 Oh!, is there anyone else	F 2		for further recommend	lations.		

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F 241 F 247 SS=D	Administrator states sweater on, that is resident.  A policy on staff bur received from the factor of the state of the sta	Director of Nursing, the d that if a resident wants a what should be done for the rnout was requested but not acility.  The policy was received on gnity which stated that reated with dignity and respect policy read, "Staff shall speak lent at all times, including dent by his or her name of	F 241			9/24/15
	by: Based on interview facility failed to provo roommate for 1 of 2 admission, transfer Findings Include: R30 had been interp.m. at which time schanges every coul was not given notic moved into their sh	NT is not met as evidenced  y, and document review, the vide adequate notice of a new 2 residents (R30) reviewed for y, and discharge.  viewed on 8/31/15, at 6:44 stated he has had roommate ple of months and added he e when his current roommate ared room. Furthermore, R30 ve liked to receive notice		R30 will receive notice of roommarchange every time there is such chall residents of Adams Health Care Center will receive notice of roommarchange per facility policy when they receiving a new roommate and who change in roommate is to occur. Nursing staff and Social Services in-serviced regarding providing advanctice of a change in roommate or Policy and Procedure for room chareviewed.  Administrator, Social Services and	ange. e nate y will be en a vanced room. nges	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 247	licensed social work recent change in roto locate any documnotified he was recent the new resident's at A facility Room & R dated 8/2014, identification included, " All resident when they will be reand added, " All resident when a change in reflect the the the they will be reand added, " All resident to the they will be reand added, " All resident to the they will be reand added, " All resident to the they will be reand added, " All resident to the they will be read added,	te(s) change.  on 9/1/15, at 2:46 p.m.  ker (LSW)-A stated R30 had a commate, but she was unable nentation R30 had been eiving a new roommate prior to admission.  commate Changes policy ified a procedure which idents will be given notice eceiving a new roommate"  esidents will be given notice commate is to occur. Adams will explain why the change in sary"  RVICES BY QUALIFIED		247	designee will audit once per week f month and once per month for 3 me to monitor for compliance.  R20's care plan is correctly implem as of 09/03/2015. All residents care plan will be correctly implemented at Adams Health Care Center.  Nursing staff education held on	nented	9/24/15	
	diagnoses that include depression, demen	ecord identified R20 had uded Alzheimer's disease, tia muscle weakness and rophy. R20's Quarterly			Nursing staff education held on September 24, 2015 to review how correctly implement a resident care DON and/or her designee will cond audit one per week for 1 month, on	plan. uct an		

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F 282	dated 7/17/15 state impairment. The M not steady when m and needed one petransfers and walki the last quarter she injury and one fall velectronic medical 4/28/15, 5/11, 15, 1 8/9/15, 8/12/15, ansince 4/28/15.  R20's Falls Care P had a history of fall deficiencies and walimitations and inable device. The Car pl was unsteady and and did not use the assistance. An approximation of the state of t	(MDS) an assessment tool of R20 had severe cognitive MDS also indicated R20 was oving from seating to standing, erson to physically assist withing. R20's MDS stated during that more than 2 falls without with injury. Review of R20's record revealed falls on 7, & 27/2015, 6/10/15, 7/4/15, d 8/18/15 a total of 10 falls alian, dated 7/21/15, stated R20 is related to cognitive as unaware of her physical willity to safely transfer without a an continued that R20's gait she continued to self-transfer a call light or ask for proach started 8/19/15, stated thy and place in supervised	F 282	month for 3 months to monitor compliance. Results will be forwarded to C Committee for further recomm	QA/QI	
	R20 was limited in related to bone/car weakness, unstead history of falls. App	e Plan, dated 7/21/15, indicated mobility and ability to transfer tilage disorder and generalized by gait, need for device and a proaches included do not leave one when in wheelchair.				
	herself down the fa Assistant (NA)-C a about going to her wheelchair to her ro When arriving at R R20's wheelchair fa	a.m., R20 was propelling cility's West hallway. Nursing oproached R20, talked to her room and pushed R20's oom in the North hallway. 20's room, NA-C positioned acing a television set, locked and left. As soon as NA-C left				

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	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP COI 810 WEST MAIN STREET ADAMS, MN 55909	<b>.</b>	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
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F 282	push her locked wh was informed of the intervened, assisting. In an interview on Sconfirmed she took sitting in her wheele aware that R20 sels she was not to be I her room. NA-C st care plan updates is shift and staff can gresident's care plar approach, "do not I her wheelchair" wa "I'm sorry. I didn't I In an interview on SDirector of Nursing changes are common report sheet. The I 24-hour report sheet to it throughout the there is a verbal reshift, and staff liste. In a review of the fadocumentation was 7/21/15 care plan of in her room in her was requested but.	od up, turned, and attempted to neelchair backwards. NA-E e situation and quickly ng R20 to bed.  6/2/15, at 8:45 a.m., NA-C R20 to her room and left her chair. NA-C stated she was f-transfers, but denied knowing eft alone in her wheelchair in ated that she learns about in report at the start of each go online and look at each ns. When the care plan eave R20 alone in her room in s shown to NA-C, she stated, know."  6/3/15, at 9:52 a.m., the (DON) stated that care plan nunicated to staff on a 24-hour DON stated staff look at the et during report and can refer ir shift. The DON also stated port at the beginning of each in to updates at that time.  6. acility 24-hour report sheet no se found referencing R20's change to not leave R20 alone wheelchair.	F 28				
		ge on the 24-hour report					

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F 282 F 314 SS=D	resident, the facility who enters the facil does not develop prindividual's clinical of they were unavoidal pressure sores received.	ENT/SVCS TO RESSURE SORES  rehensive assessment of a must ensure that a resident ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and healing, prevent infection and	F 282 F 314		9/24/15
	by: Based on observat review, the facility for assess and develop risk of pressure ulcoresidents (R57) rev who had redness of the findings include: R57's admission Moreon assessment tool day had intact cognition with transfers and by pressure ulcer developressure ulcers. R57's Pressure Ulcon dated 7/14/15, iden pressure ulcers or risk for pressure ulcers under the first pressure ulcers or risk for pressure ulcers and the pressure ulcers.	ion, interview, and document ailed to comprehensively o interventions to reduce the er development for 1 of 3 lewed for pressure ulcers and in their spine and sacrum.  Inimum Data Set (MDS) an ted 7/14/15, identified R57, required limited assistance led mobility, and was at risk of elopment but had no current ers Care Area Assessment tified R57 had no current edness on his skin, but was at ter development related to his stially in the areas of "bony"		R57 started a treatment of Skin Repa Cream to sacrum on 09/02/2015, and offered a specialty mattress but refuse until 09/21/2015. Resident is independ in all mobility around facility and does thave any pressure ulcers currently. All residents of Adams Health Care Center who are at risk of developing pressure ulcers will be promptly identified and the facility protocol to promote heat of current pressure ulcers will also be implemented. Nursing staff in-serviced on how to promptly identify potential pressure development and implementation of facility protocol to promote healing of current pressure ulcers. DON and/or her designee will conduct audit once per week for one month and once per month for 3 months to monitofor compliance.	was d ent not  ied aling

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F 314	For Predicting Presassessment dated "AT RISK" of press not identify R57 to time.  R57's progress not R57 "c/o [complain was redhe [R57] nursing home he had break down." An a and nine days late identified an, "Asso blanchable redness prominences me [centimeters] X [by] added, "Will call MI dressing to protect However, the noted immediate interven pressure ulcer deverous the developed redness of nickels." No furt any comprehensive developed redness any interventions to risk of worsening of development.  During interview on stated he still had research identified and research interventions to risk of worsening of development.	7's most recent Braden Scale sure Sore (ulcer) Risk 7/29/15, identified R57 to be ure ulcer development, but did have any current ulcers at the estated 7/11/15, identified ed of] pain in coccyx and it wants an air bedin other ad air bed and he did not dditional note dated 7/20/15 after 7/11/15 progress note, essed sacral area has some s has prominent bony easures approximately 5 cm 5 cm." The progress note D [medical doctor] for order for area from skin breakdown." It did not identify any tions to reduce R57's risk of elopment. Furthermore, on a safter initial identification of eless found in progress note identified, inging on lower backnoted a con lower spine about the size ther progress notes identified assessment of R57's newly on his sacrum and spine, nor on the beautified to reduce the result of the progress on the spine and 19/1/15, at 2:55 p.m. R57 edness on his spine and	F 314	, , , , , , , , , , , , , , , , , , ,		
	R57 stated he deve	ne "bony part" of his buttocks. Plops redness on his sacrum ne to time", and was applying				

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		245509	B. WING			09/0	03/2015
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CO 810 WEST MAIN STREET ADAMS, MN 55909	DE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 314	them when he note added he had reque placed on his bed to of pressure ulcer de [facility] didn't have  R57's care plan dat "at risk for pressure nutrition and friction having his skin rem not identify R57 to having his skin rem not identify R57 to have pressure ulcers.  When interviewed assistant (NA)-G st independent" with have pressure ulcers that the pressure ulcers that the pressure ulcers are ulcers that the pressure ulcers that the pres	on the state of th	F3	314			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 314	approximately 4 inconon-blanchable red measured at "three [centimeters]", alon vertebrae (spine) wo pushed on. The DO air bed in place to rulcer development to breakdown." Furthad not been compose pressure ulcer risk Scale (7/29/15) as a developing these are and spine. On 9/3/1 stated she had contained and had been told frapplication of skin record and R57 had pressure ulcer deverdness on his sacrit", but added, R57 re-assessed.	his sacrum that was hes in size, with a center of ness which the DON by two and a half g with some red areas on his hich were blanchable when ON stated R57 should have an educe his risk of pressure as he "definitely has potential ther, The DON stated R57 rehensively re-assessed for since the most recent Braden she was not aware R57 was reas of redness on his sacrum 5, at 9:04 a.m. the DON sulted with a wound nurse, R57 should have a daily epair cream. Furthermore, e reviewed R57's medical d not been re-assessed for elopment since developing the rum and spine, "I do not see should have been	F3	14			
F 315 SS=D	Prevention and Tre read, "It is the polici assess residents w increase the risk for to implement preve the policy directed so "Comprehensive Exfor a newly develop 483.25(d) NO CATHRESTORE BLADD	valuation of Skin Risk Factors" ed pressure ulcer. HETER, PREVENT UTI, ER	F3	315			9/24/15
	Based on the reside	ent's comprehensive					

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F 315	resident who enters indwelling catheter resident's clinical coatheter resident's clinical coatheterization was who is incontinent of treatment and servinfections and to refunction as possible.  This REQUIREMENT by:  Based on observative, the facility freassess 1 of 3 resurinary incontinent continence function.  Findings include:  R3's admission Mir 4/15/15, indicated frimpairment, was all had no urinary toile. Quarterly MDS date resident had mode impairment, was of and had no urinary.  R3's current care pas being continent. R3 is to remain connext review. Intervewere to have episoto the nurse and champuterized charterized charterized.	cility must ensure that a sthe facility without an is not catheterized unless the condition demonstrates that a necessary; and a resident of bladder receives appropriate ices to prevent urinary tract store as much normal bladder expected.  NT is not met as evidenced tion, interview and document ailed to comprehensively idents (R3) reviewed for expected and had a change in an interview and document ailed to comprehensively idents (R3) reviewed for expected and had a change in an interview and ting program. A review of R3's expected are to the received and the tolerate the received and the tolerate that were put in place des of incontinence reported that the point of care a state of the continence reported that the point of care a state of the cate of the point of care a state of the continence reported that the point of care a state of the cate of the point of care a state of the cate of the point of care a state of the cate of the point of care a state of the cate of the point of care a state of the cate of the point of care a state of the cate of the point of care a state of the point of the po	F 315	R3 72 hour bowel and bladder assessment initiated on 09/03/2011 revealed that he is continent of bow occasional incontinent of urine. All residents of Adams Health Care Center will be assessed for newly identified incontinence and necess changes will be implemented to refure current status.  nursing staff in-serviced on 09/24/2 review facility policy and procedure newly identified incontinence and frimplementation of necessary changer reflect current status.  DON and/or her designee will concaudit once per week for one month once per month for 3 months to more for compliance.  Results will be forwarded to QA/QI Committee for further recommendations.	ary flect 2015 to for ges to fluct an and onitor	

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 315	6/18/15, indicated the bladder.  The facility Nursing Bladder Category Foursing assistants or residents) reviewed indicated that R3 have urinary incontinence.  When interviewed of Nursing Assistant (I sometimes has to dincontinence.  When interviewed of stated that she soil least half the time potated that she had whenever her bedded be changed. R3 stated that she had whenever her bedded be changed. R3 stated that she had whenever her bedded be changed. R3 stated that she incontinence happed occasionally during.  When interviewed of licensed practical in nursing assistants and nursing staff any instated that she is not R3's urinary incontinence this more ported to the licensed pirector of Nursing.	Assistant Point of Care Report worksheet (what the use to document cares to I from 6/18/15 through 9/3/15 ad thirty-six episodes of e.  On 9/2/15, at 9:32 a.m., NA)-E stated that he change R3's bedding due to on 9/2/15, at 1:47 p.m., R3 is her underwear with urine at orior to going to the toilet. She told the nurse in the past ing was soiled and needed to ated that her urinary ened mostly at night but the day.  On 9/3/15, at 9:49 a.m., urse (LPN)- B, stated that the are supposed to report to the stances of incontinence. She ot aware of ever being told of	F 31				

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F 315	urinary incontinence resident had episod is something that stated that the have notified the nushe would have expected to have been done of urinary incontine.  When interviewed of stated that if a residincontinence she we computerized chart. She stated that she where R3 did have incontinence where	e. She stated that if the les of urinary incontinence that last should report right away. nursing assistants should arising staff. She stated that bected a bladder assessment if the resident had an episode nce.  on 9/3/15, at 1:51 p.m., NA-F lent had an episode of urinary ould first document it in the and then let the nurse know. did notice at least one time an episode of urinary the resident had soiled pants hanged but no could not	F 315			
F 323 SS=D	and Bowel Assessndated 9/22/15, it standards Health Care ensure that each rebladder and /or bow given the opportunitiestore as much not function as possible Assessment will be significant change in 483.25(h) FREE OF HAZARDS/SUPER  The facility must entending as is possible; and		F 323			9/24/15

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F 323	Continued From pa	ge 13	F 323				
	by: Based on observatoreview the facility fawhile smoking for 1 for smoking; failed interventions for 1 owith chronic falls his grab bar for safe us with a grab rail attarepositioning and g to prevent misuse of to manufacturers resoft 1 resident (R3) a sustaining an injury.  Findings include:  LACK OF SMOKIN SAFETY:  R62 was admitted to diagnoses to include obstructive chronic muscle weakness, disorder. R62 had a through Mower Coulon 8/31/15 at 1:15 parking lot near the wheelchair, smokin surveyors as they weaknession Minimum.	G ASSESSMENT FOR  to the facility on 7/28/15 with e: acute respiratory failure, airway, difficulty in walking, memory loss, and tobacco use a guardian appointed to her		R3 has been educated on safe use wheeled walker per manufacturer recommendations, R20's care plan intervention is implemented, R32'g bar is securely attached to his bed a R62 has been assessed for smokin safety.  All residents of Adams Health Care Center are receiving adequate supe and assistance devices to prevent accidents.  Nursing staff in-serviced on 09/24/2 review facility policy for assessment resident smoking, on using mobility per manufacturer recommendation, how to correctly implement a reside plan of care and on how to secure a bar safely.  DON and/or her designee will conducted audit once per week for one month once per month for 3 months to mo for compliance.  Results will be forwarded to QA/QI Committee for further recommendation.	for fall rab and g ervision to f device on ent's a grab uct an and nitor		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245509	B. WING			09/	03/2015
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, Z 810 WEST MAIN STREET ADAMS, MN 55909	IP CODE	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROP	BE	(X5) COMPLETION DATE
F 323	six; indicating seve revealed R62 requiassist with locomot supervision oversig R62's care plan date cigarette smoking. Resident has been smoking but contineeducation including health and safety. If the seview of R62's pronotations of R62 of 8/6/15, 8/9/15, 8/17. On 09/01/15 at 3:48 was interviewed requot supposed to be wearing a nicotine medication]. With the remember what we director of nursing to her. If we catch hinto the facility and cigarette." SS-A was to safely smoke, "Note facility. They [resident the smoke free."  On 09/03/15 at 9:00 administrator were receiving a smoking because we are a shas been educated She does still smokes.	rental status (BIMS) score of re impairment. MDS also red a one person physical ion off unit requiring ht, encouragement, or cueing. Resident smokes cigarettes. advised the facilities policy on ues to smoke despite the risks of smoking on Goal: Resident will be free ed to] smoking."  Ogress notes revealed oserved smoking on: 8/3/15, and 8/30/15.  Op.m. social services (SS)-A garding R62 smoking. "She is smoking at all because she is batch [a physician ordered er memory she doesn't have talked about. The (DON) has tried to explain that her smoking we redirect her don't let her finish her is asked if R62 was assessed to, because we are a smoke esidents] are just supposed to moke free facility. She [R62] numerous times not smoke.	F3	323			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		` /	E SURVEY PLETED
		245509	B. WING			09/0	03/2015
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP C 810 WEST MAIN STREET ADAMS, MN 55909	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD	BE	(X5) COMPLETION DATE
F 323	outside smoking so She has a patch [N medication]. We ed has been smoking. assessment comple Adams Health Care 5/24/10 read, "III. P Care Center is a snor use of smoking r building B. No sn materials will be alle Care Center's grouexcept at the follow Gazebo area on no No smoking allower Resident's will be in social services." LACK OF FOLLOW INTERVENTION OF R20's Admission Rediagnoses that include pression, demen muscular disuse at Minimum Data Set R20 had severe coalso indicated R20 from seating to start to physically assist R20's MDS stated of more than 2 falls wi injury. Review of R revealed 10 falls froz 2015.	Re, "I have never seen her I can't answer that question. icotine prescription lucate her when we know she There was no smoking eted."  The Center Smoking Policy dated rocedure; A. Adams Health noke-free facility. No smoking materials will be allowed in the noking or use of smoking owed on the Adams Health ands, including parking lots, ing locations. Employees: rth side of building Residents: d on grounds or premises. Informed on admission by  ING PLAN OF CARE	F3	23			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245509	B. WING _		09	/03/2015	
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP COD 810 WEST MAIN STREET ADAMS, MN 55909			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	herself down the far Assistant (NA)-C are about going to her wheelchair to her rowheelchair to her rowhen arriving at Richards at the room, R20 stoop push her locked who was informed of the intervened, assisting R20's Falls Care Pland a history of fall deficiencies and walimitations and inable device. The care pland was unsteady and and did not use the assistance. An apple to observe frequentarea when out of be R20's Mobility Care R20 was limited in related to bone/car weakness, unstead history of falls. Appresident in room alound in an interview on Sconfirmed she took sitting in her wheeld aware that R20 selfshe was not to be laber or om. NA-C stoare plan updates is shift and staff can get about 200 miles.	cility's West hallway. Nursing pproached R20, talked to her room and pushed R20's bom in the North hallway. 20's room, NA-C positioned acing a television set, locked and left. As soon as NA-C left and up, turned, and attempted to neelchair backwards. NA-E estituation and quickly ag R20 to bed.  Jan, dated 7/21/15, stated R20 is related to cognitive as unaware of her physical sility to safely transfer without a blan continued that R20's gait she continued to self-transfer a call light or ask for proach started 8/19/15, stated tly and place in supervised	F 32	23			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245509	B. WING _		09	/03/2015	
NAME OF PROVIDER OR SUPPLIER  ADAMS HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	approach, "do not her wheelchair" wa "I'm sorry. I didn't her wheelchair" wa "I'm sorry. I didn't her wheelchair was report sheet. The I 24-hour report sheet to it throughout the there is a verbal repshift, and staff lister. In a review of the fadocumentation was 7/21/15 care plan on the room in her was requested but. In an interview on Sconfirmed she did recare plan change in LACK OF SECURE RESIDENT SAFET. R32's Admission R including dementia. R32's Annual Minit 7/10/15, indicated for cognition, required mobility and transfer moving from sitting Care Plan indicated generalized weakned.	eave R20 alone in her room in s shown to NA-C, she stated, know."  2/3/15, at 9:52 a.m., the (DON) stated that care plan funicated to staff on a 24-hour DON stated staff look at the et during report and can refer ir shift. The DON also stated port at the beginning of each in to updates at that time.  acility 24-hour report sheet no a found referencing R20's change to not leave R20 alone wheelchair.  bur report sheet with 's 7/21/15 care plan change not received.  2/3/15, at 11:18 a.m., the DON not see any reference to the in the 24-hour report sheets.	F 3:	23			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245509	B. WING			09/03/2015	
NAME OF PROVIDER OR SUPPLIER  ADAMS HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE 810 WEST MAIN STREET ADAMS, MN 55909	E, ZIP CODE	03/30/2012	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN X (EACH CORRECTIVE CROSS-REFERENCED DEFICITION	ACTION SHOULD E TO THE APPROPRI		
F 323	mobility, transfers a approach dated 7/2 physical assist of 1 transfers; R32's colare to use an EZ st On 8/31/15, at 5:42 on R32's bed found to side and securel In an interview on SAssistant (NA)-A st maintenance man in NA-A stated she ro In an interview on SMaintenance Direct work for him on a conurse's station. ME board daily and he to fix grab bars. Mil grab bar and when "I guess I need to till In an interview on Stated that R32 uses In a follow-up interview on Stated th	and wheelchair locomotion. An 12/15, directs staff to provide -2 staff with bed mobility and mpliance varies as and staff and for transfers  1 p.m., the right hand grab bar to be easily moved from side y attached to bed frame.  1/2/15, at 7:41 a.m., Nursing ated she would tell the f she found a loose grab bar. utinely takes care of R32.  1/2/15, at 8:02 a.m., for (MD)-A stated staff put lip board that is kept at the D-A stated he checks the clip has not received any requests D-A was asked to check R32's finding it loose, MD-A stated, ghten that up."  1/2/15, at 8:14 a.m., NA-B as the grab bar to sit up.  1/2/15, at 8:22 a.m., 32 occasionally uses the grab e of the bed, as part of ord.  1/2/15 as requested and received; address maintenance or	F3	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245509	B. WING		09	/03/2015
NAME OF PROVIDER OR SUPPLIER  ADAMS HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	During observation was seated on a Ni in the hallway of the around the hallway while her arms wer resting on the hand holding onto the demotion. When observed to wheeled walkers shop conversing with proceeded to wheeled walkers and was not holding wheeled walker. Reand was not holding wheeled walkers around "quite often educate her on safe moderate cognitive but it hadn't help ar LPN-D stated sher wheeled walkers must his practice, but are do because "She [I walker while it is in observed R3's four had a label fixed to use as a wheelchal someonelock har seated."	on 8/31/15, at 2:34 p.m. R3 ova brand four wheeled walker e North Unit. R3 wheeled while seated on the device e crossed with her elbows lles of the device. R3 was not evice for security when in erved on 9/1/15, at 9:27 a.m. ed on the seat portion of her er in the doorway of the beauty ith other residents. R3 el herself down the hallway room while seated on the four 3 again had her arms crossed g onto the walker for security.  On 9/2/15, at 12:59 p.m. eurse (LPN)-D stated R3 sits ed walker and pushes herself. The staff had tried to be use of walker, despite her eimpairment, on not doing so, and R3 continued to do it. It was unaware of what the four lanufacturer advised regarding dided she felt it was unsafe to R3] can easily fall" off the motion. Further, LPN-D wheeled walker and stated it the leg which read, "DO NOT	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245509	B. WING		09/	03/2015	
NAME OF PROVIDER OR SUPPLIER  ADAMS HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909	·		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		LD BE	(X5) COMPLETION DATE	
F 323	dangerous." Further therapy should of be	ge 20 d on the walker "because its ermore, the DON added, een contacted and an ave been completed for R3's	F3	323			
F 329 SS=D	read, "Safety Warni included, "DO NOT transport someone' scoot around while	GIMEN IS FREE FROM	F3	329		9/24/15	
	unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequen	g regimen must be free from  An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of excessive which indicate the dose or discontinued; or any expenses above.					
	resident, the facility who have not used given these drugs utherapy is necessar as diagnosed and crecord; and residen drugs receive gradubehavioral intervent	chensive assessment of a must ensure that residents antipsychotic drugs are not unless antipsychotic drug by to treat a specific condition documented in the clinical to the use antipsychotic and dose reductions, and tions, unless clinically an effort to discontinue these					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245509	B. WING		09/0	3/2015
NAME OF PROVIDER OR SUPPLIER  ADAMS HEALTH CARE CENTER			8	STREET ADDRESS, CITY, STATE, ZIP CODE 110 WEST MAIN STREET ADAMS, MN 55909		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Continued From pa	ge 21	F 329			
	by: Based on observatoreview, the facility adverse consequer while wearing a nic (R62) who was on a which included a nismoke even though warning in regards patch and failed to from a psychiatric eresidents (R12) reviewed in the facility of the facility o	ition, interview, and record failed to monitor for significant inces of smoking cigarettes of tine patch for 1 of 1 resident a smoking cessation program cotine patch and chose to in the nicotine patch had a to smoking while wearing the follow up on recommendations evaluation timely for 1 of 2 iewed for unnecessary  MENT TO DETERMINE IF ITS WERE IMMANENT FOR E PATCH AND SMOKING AT the facility on 7/28/15 with the acute respiratory failure, airway, difficulty in walking, memory loss, and tobacco use a guardian appointed to her unity.  p.m. R62 was observed in the garage, sitting in her g a cigarette. R62 waived to walked into the facility.  Pedication Administration ealed an order for "nicotine apply patch transdermally one		R12's physician recommendations now followed per doctor's order. R62's nicotine patch has been discontinued per doctor's order as continues to smoke.  All residents of Adams Health Care Center will be assessed and monitor any significant adverse consequence combined substances and medicat and will receive all medical provide recommendations for medications timely manner.  Nursing staff in-serviced on 09/24/2 regarding the implementation of me provider recommendations for significant adverse consequences with respect psychotropic medications, and the monitoring for significant adverse consequences of smoking while we nicotine patch.  DON and/or designee will conduct audit once per week for one month once per month for 3 months to mother for compliance.  Results will be forwarded to QA/QI Committee for further recommendations.	she ored for ces of ions r's in a 2015 edical ificant ot to earing a an and onitor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245509	B. WING		<del></del>	09/	03/2015
NAME OF PROVIDER OR SUPPLIER  ADAMS HEALTH CARE CENTER				810	EET ADDRESS, CITY, STATE, ZIP CODE WEST MAIN STREET AMS, MN 55909	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Continued From pa	ge 22	F 3	29			
	time a day. Remove patch on." R62's M	e old patch before placing new AR indicated R62 was cotine patch daily 8/1/15					
	assessment tool da	m Data Set (MDS) an ated 8/4/15 revealed R62 had a nental status (BIMS) score of re impairment.					
	R62's care plan dated 8/10/15 read "problem: cigarette smoking. Resident smokes cigarettes. Resident has been advised the facilities policy on smoking but continues to smoke despite education including the risks of smoking on health and safety. Goal: Resident will be from injury r/t [related to] smoking."						
notations of R62 8/6/15, 8/9/15, 8/ Furthermore, the documented nor nicotine patch ha physician had be		ogress notes revealed observed smoking on: 8/3/15, 7/15, and 8/30/15. was no information ovided in regards to the ng been removed, nor if the informed of the resident ring the nicotine patch.					
	was interviewed req "She [R62] is not so because she is wea memory she doesn talked about. The d explain that to her.	9 p.m. social services (SS)-A garding R62 smoking and said, upposed to be smoking at all aring a nicotine patch. With her 't remember what we have lirector of nursing has tried to If we catch her smoking we a facility and don't let her finish					
		.m. the director of nursing wore a nicotine patch but did					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245509	B. WING		09	/03/2015	
NAME OF PROVIDER OR SUPPLIER  ADAMS HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, 810 WEST MAIN STREET ADAMS, MN 55909	<b>.</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		CTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETION DATE	
F 329	not know if the nico R62 was known to R62 was not able to foot further testing if he warr Administration, date you continue to smouse nicotine gum, on nicotine containing product do not smouse patch. The nicotine entering the bloods you take off the pat Nicotine patch direct completely when you LACK OF TIMELY IFOLLOWING PSYORECOMMENDATION R12 had been administration orders R1 with diagnosis inclusion. The physician orders R1 with diagnosis inclusion orders R1 with diagnosis inclusion. The physician order receiving the medical (antidepressant medical Apsychiatric evaluation of the referral form from the referral from the referral form fro	tine patch was removed when have been smoking.  Inings from the Food and Drug ed 1/2010 read, "Do not use if oke, chew tobacco, use snuff, or use another patch or other productsWhen using this ke even when not wearing the in your skin will still be tream for several hours after ch."  Etions include"stop smoking bu being using the patch."  MEDICATION ADJUSTMENT CHIATRIC DNS:  Itted according to the current 12 was admitted to the facility ding anxiety and insomnia.	F 3	329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245509	B. WING _		09	/03/2015	
NAME OF PROVIDER OR SUPPLIER  ADAMS HEALTH CARE CENTER   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 329  Continued From page 24  On 7/6/15 a psychiatric evaluation was completed. Review of the final report identified: "From a medication perspective, he is being treated with clonazepam 1 mg 2 times a day and 2 mg at bedtime. Benzodiazepines in dementia can be complicating problems cognitively as well as causing paradoxical agitation and exacerbating anxiety. In addition, it also elevates the risk of falls significantly. Under the circumstances, mirtazapine [antidepressant]				STREET ADDRESS, CITY, STATE, ZIP C 810 WEST MAIN STREET ADAMS, MN 55909			
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 329	On 7/6/15 a psychic completed. Review "From a medication treated with clonaze 2 mg at bedtime. E can be complicating as causing paradox exacerbating anxie the risk of falls sign circumstances, mir medication] would be used, starting the dot to potentially 15 to sleep as well as with number of problem noticed at night and the current dose of helpful, hence this consideration." "From assessment perspensive gradually tapering to current total 4 mg at 4 weeks completely anxiety remains and treatment is necessing quetiapine [antipsyce 25 mg could be util During an interview licensed practical in recommendations in been followed. She was not scanned in been. LPN-A state referral back she slight stated apparer didn't get addresse report) was at the complete the stated apparer didn't get addresse report) was at the complete the stated apparer didn't get addresse report) was at the complete the stated apparer didn't get addresse report) was at the complete the stated apparer didn't get addresse report) was at the complete the stated apparer didn't get addresse report) was at the complete the stated apparer didn't get addresse report) was at the complete the stated apparer didn't get addresse report) was at the complete the stated apparer didn't get addresse report)	atric evaluation was v of the final report identified: n perspective, he is being epam 1 mg 2 times a day and Benzodiazepines in dementia g problems cognitively as well kical agitation and ty. In addition, it also elevates ificantly. Under the tazapine [antidepressant be an ideal medication to be loses of 7.5 mg, increasing it 30 mg as needed to help with th anxiety. I understand that a atic behaviors have being d based on current evidence, clonazepam is not being should be an appropriate om an anxiety/cognitive risk ective, i would recommend a the clonazepam from the a day over a period of the next y and stopped. In its place if issue and symptomatic sary, then small doses of chotic medication] at 12.5 to	F 32	29			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245509	B. WING		09/03/2015	
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909	00.00.2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 428 SS=D	A policy regarding of none provided. 483.60(c) DRUG RIRREGULAR, ACT The drug regimen of reviewed at least of pharmacist. The pharmacist muthe attending physicians and the strending physicians are provided to the strending physicians are physicians are provided to the strending physicians are provided to the strending physicians are provided to the strending physi	e what changes to R12 n needed changing. consult was requested and EGIMEN REVIEW, REPORT	F 329		9/18/15	
	by: Based on interview consulting pharmace follow up recommended evaluation for 1 of 2 unnecessary medical findings include: R12 had been admitted physician orders R1 with diagnosis included The physician order receiving the medical (antianxiety medical)	itted according to the current 12 was admitted to the facility Iding anxiety and insomnia. rs also identified R12 as		The consulting pharmacist will identi missing follow-up recommendations any psychiatric evaluation in a timely manner.  All physician's recommendations regarding psychotropic medications identified and followed-up in a timely manner for all residents of Adams He Care Center.  The pharmacy consultant in-serviced 09/18/2015 regarding the implementation of medical provider recommendation with respect to psychotropic medication DON will conduct an audit once per refor 3 months to monitor for compliance Results will be forwarded to QA/QI	from  will be ealth I on ation s ions. month	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245509	B. WING		····	09/0	03/2015
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		81	REET ADDRESS, CITY, STATE, ZIP CODE O WEST MAIN STREET DAMS, MN 55909		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	physician due to incand an evaluation of and an evaluation of the referral form from the diagnosis of cognition of 7/6/15 a psychiat completed. Review "From a medication the rest of falls sign circumstances, mind the risk of falls sig	ation was ordered by the creased anxiety and behaviors was attempted on 5/28/15. The control of the record and docation it was faxed from the acility on 9/3/15. Review of me the appointment read, agnitive testing, although R12 as well at all. Will attempt its more alert." A new we disorder was identified.  Attric evaluation was a for of the final report identified: a perspective, he is being a problems cognitively as well attain and any. In addition, it also elevates ificantly. Under the cazapine [antidepressant are an ideal medication to be coses of 7.5 mg, increasing it and maxiety. I understand that a catic behaviors have being a based on current evidence, clonazepam is not being should be an appropriate of an anxiety/cognitive risk active, i would recommend a the clonazepam from the aday over a period of the next of and stopped. In its place if issue and symptomatic sary, then small doses of chotic medication] at 12.5 to	F 4	28	Committee for further recommendation of the commendation of the co	itions.	

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED		
		245509	B. WING		09	/03/2015
	ROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE
F 428	licensed practical n recommendations f been followed. She was not scanned in been. LPN-A stated referral back she sh She stated apparer didn't get addressed report) was at the corequested it be faxed have it to determine medication regiment. A policy regarding conne provided.  483.60(b), (d), (e) E LABEL/STORE DR  The facility must en a licensed pharmacof records of receip controlled drugs in accurate reconciliat records are in order controlled drugs is reconciled.  Drugs and biological labeled in accordant professional princip appropriate access	on 09/03/2015, at 10:11 a.m. urse (LPN)-A verified the from the psych eval had not estated that the psych referral to the facility and should have dif the nurse didn't get the hould have called to get it. Intly no one called about it so it d. She stated, this (the final dinic and she had just ed to them, the facility did not estated changing.  Consult was requested and DRUG RECORDS, UGS & BIOLOGICALS  In ploy or obtain the services of sist who establishes a system and disposition of all sufficient detail to enable antion; and determines that drug or and that an account of all maintained and periodically als used in the facility must be not with currently accepted bles, and include the	F 4	128		9/24/15
		State and Federal laws, the II drugs and biologicals in				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245509	B. WING		09/03/2015	
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER	8	STREET ADDRESS, CITY, STATE, ZIP CODE B10 WEST MAIN STREET ADAMS, MN 55909		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION	
F 431	controls, and perminave access to the  The facility must propermanently affixed controlled drugs list Comprehensive Drucontrol Act of 1976 abuse, except when package drug distriquantity stored is more be readily detected.  This REQUIREMENT by:  Based on interview facility failed to ensimedication had been outdated dose was resident (R66) new.  Findings include:  Upon review of the storage room on 05 expired vial of Aplis derivative; used in a skin testing] solution for use in the medical had an open date of 9/30/15 however, the calculated in error aup to 30 days after	nts under proper temperature tonly authorized personnel to keys.  ovide separately locked, decompartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to the facility uses single unit bution systems in which the inimal and a missing dose can	F 431	All expired medications are discard upon date of expiration and outdat doses will not be administered to a residents of Adams Health Care Ce Nursing staff in-serviced on 09/24/2 regarding removal of expired medic and ensuring that outdated doses where administered to any residents. DON and/or designee will conduct audit once per week for one month once per month for 3 months to mo for compliance.  Results will be forwarded to QA/QI Committee for further recommendations.	ed ny enter. 2015 cation vill not an and onitor	

	( )		B) DATE SURVEY COMPLETED		
		245509	B. WING _		09/03/2015
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 431	(DON) was asked he was to remain in use. It think it is 60 days told me." Minutes lamy fault I just called days." The DON vereceived a dose fro DON then removed supply.  R66 was admitted to Medication Administration.	.m. the director of nursing now long a vial of PPD solution are after opening and she said, that is what the pharmacist after the DON added, "That's differ that one resident, R66, m the expired Aplisol vial. The the Aplisol vial from stock of the facility on 8/31/15. R66's tration Record (MAR)	F 43	31	
F 465 SS=D	8/31/15.  Facility document, I Expiration Dates, u Tuberculin PPD, dil more than 30 days possible oxidation a effect potency."  An Aplisol package more than 30 days 483.70(h) SAFE/FUNCTIONAE ENVIRON  The facility must pro	Medications With Shortened ndated, indicated "Aplisol, uted, injection;vials in use should be discarded due to and degradation which may insert read, "Vials in use for should be discarded."  AL/SANITARY/COMFORTABL  Divide a safe, functional, ortable environment for the public.	F 46	55	9/24/15
	by: Based on observat	NT is not met as evidenced ion & interview, the facility exhaust vents were cleaned		All exhaust vents were cleaned to maintain a sanitary bathroom environ	ment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245509	B. WING		_ 09/	03/2015	
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STA 810 WEST MAIN STREET ADAMS, MN 55909			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCEI	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 465	to maintain a sanita 17 out of 23 bathro 107, 108, 109, 112, 131, and 135) used bedrooms adjoining. Findings Include:  Upon entrance to the resident bathroom have visible heavy cover and on the grand	ary bathroom environment in oms (101, 102, 103, 105, 106, 114, 124, 125, 126, 128, 129, 1 by residents who reside in g these bathrooms.  The facility on 8/31/15 the in room 128 was observed to dust present on the vent grille rille inside the vent. Upon on 9/1/15 revealed 17 out of oms in rooms 101, 102, 103, 109, 112, 114, 124, 125, 126, 135 to have heavy surface covers and on the grille inside one dust was visible from the	F4	and will be cleaned of The Maintenance st review all bathrooms schedule. The Environmental sconduct an audit we thereafter to monitor Results will be forward.	aff was in-serviced to s vents cleaning  Services Director will bekly then monthly r for compliance.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245509	B. WING		09/	/03/2015	
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, Z 810 WEST MAIN STREET ADAMS, MN 55909			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 465	dust and needed to Resident Room Cle read, "Monday, C under TV, mop out fixtures (bathroom) Policy and Procedu 1/15/15 read, "Each take a duster and c Adams Health Care when done. Bi-Ann by maintenance de	eaning Schedule, undated clean bathroom vents, dust linen rooms floors, dust light"  The for Cleaning Vents, dated in Monday housekeeping will clean all bathroom vents in the Center. Staff will check off ually vents will be taken down partment and cleaned out I as needed. Duct work will be	F 4	165			

6509023

PRINTED: 09/30/2015 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 09/02/2015 245509 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **810 WEST MAIN STREET** ADAMS HEALTH CARE CENTER **ADAMS, MN 55909** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (FACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 **INITIAL COMMENTS** K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Adams Health Care Center 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 EPOC Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES** ( K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

St Paul, MN 55101-5145, or

TITLE

Electronically Signed

09/25/2015

(X6) DATE

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.

Facility ID: 00754

PRINTED: 09/30/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUP IDENTIFICATION		I ` '		CONSTRUCTION 11 - MAIN BUILDING 01	(X3) DATE SUF COMPLET	
		245509	B. WING	3		09/	02/2015
	PROVIDER OR SUPPLIER HEALTH CARE CENT	ER		81	REET ADDRESS, CITY, STATE, ZIP CODE 0 WEST MAIN STREET DAMS, MN 55909		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	Continued From pa	age 1	K	000			
		RRECTION FOR EACH OT INCLUDE ALL OF THE DRMATION:					area area area area describina en
	1. A description of what has been, or will be, done to correct the deficiency.						
	2. The actual, or pr	roposed, completion date.					
	3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.						
	building with no bas constructed at 2 dif building was constr to be of Type II(111	Care Center is a 1-story sement. The building was ferent times. The original ructed in 1976 and determined ) construction. In 1992, an ructed and determined to be of ruction					
	PLEASE RETURN CORRECTION FO DEFICIENCIES ( K-TAGS) TO:	THE PLAN OF R THE FIRE SAFETY					
	Health Care Fire In State Fire Marshal 445 Minnesota St., St Paul, MN 55101	Division Suite 145	and the contract of the contra				
	By email to: Marian.Whitney@s Angela.Kappenmar		100000000000000000000000000000000000000				
		RRECTION FOR EACH T INCLUDE ALL OF THE					Manufacture on the second

Event ID: SG3J21

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245509	B. WING			09/	02/2015
	PROVIDER OR SUPPLIER HEALTH CARE CENT	<u> </u>		S 8	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET DAMS, MN 55909		VACAVIV
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	FOLLOWING INFO  1. A description of value to correct the deficing control of the correct the deficing control of the facility is fully seemed to the facility	PRMATION: what has been, or will be, done ency. oposed, completion date.	К	000			
K 054 SS=F	the corridors and spis monitored for automotification.  The facility has a cacensus of 42 beds.  The requirement at NOT MET as evide NFPA 101 LIFE SA	paces open to the corridor that comatic fire department apacity of 49 beds and had a at the time of the survey.  42 CFR, Subpart 483.70(a) is need by: FETY CODE STANDARD	K	054			10/5/15
36-1	activating door hold maintained, inspect with the manufacture.  This STANDARD is Based on documer interview, the facility system in accordant 2000 NFPA 101, Ch	detectors, including those l-open devices, are approved, led and tested in accordance rer's specifications. 9.6.1.3 s not met as evidenced by: ntation review and staff ly failed maintain the fire alarm ce with the requirements of napters 19.3.4.1, 9.6.1.4, 1999 (-3.2. The deficient practice)			The smoke detector sensitivity test scheduled to be completed on 10/0 by Simplex Grimell and will be documented. The annual fire alarm report now co	)5/2015	

PRINTED: 09/30/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 09/02/2015 245509 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **810 WEST MAIN STREET** ADAMS HEALTH CARE CENTER **ADAMS, MN 55909** PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Continued From page 3 K 054 K 054 all the required information per NFPA 72. could affect all 42 residents. The Maintenance Director in-serviced regarding maintenance of fire system in Findings include: accordance with the requirements of 2000 NFPA 101 and regarding the fire alarm On facility tour between 9:30 AM and 12:30 PM on 09/02/2015, the review of the annual fire alarm The Maintenance Director is responsible inspection and testing report from Schmitz Electric, dated 04/23/2015, indicated that the to monitor for compliance. following: 1. No documentation for smoke detector sensitivity testing, last documented test was on 8/5/2013 2. The annual fire alarm report does not contain all the required information per NFPA 72 These deficient practices were confirmed by the Facility Maintenance Director (JK) at the time of discovery. 9/24/15 K 144 NFPA 101 LIFE SAFETY CODE STANDARD K 144 SS=F Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. This STANDARD is not met as evidenced by: The emergency generator will be run Based on documentation review and staff monthly and documented in the monthly interview, the facility failed to run the emergency generator log each time it is completed. generator in accordance with the requirements of

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245509	B. WING			09/0	02/2015
	PROVIDER OR SUPPLIER	ER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET DAMS, MN 55909		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 144	Chapter 6.4.2. The all 42 residents.  Findings include:  On facility tour betwon 09/02/2015, door monthly generator I documentation for the 2014 through Augu  This deficient pract Facility Maintenance discovery.  *TEAM COMPOSITE	deficient practice could affect deficient practice could affect ween 9:30 AM and 12:30 PM dementation review of the ogs revealed there was not the monthly run for December st 2015.  Index was confirmed by the deficient of the d	K	144	The Maintenance Director was in-son 09/24/2015 regarding generator inspection and exercise under load minutes per month.  The maintenance Director is respot to monitor for compliance.	weekly for 30	
	No documentation generator run for D through August 201	for monthly emergency ecember 2014 and January 5.					

STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245509	B. WING	·		09/	02/2015	
NAME OF PROVIDER OR ADAMS HEALTH CA		ER			STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909	·		
PREFIX (EACH I	DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX.	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
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Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted September 17, 2015

Mr. Donald Flack III, Administrator Adams Health Care Center 810 West Main Street Adams, Minnesota 55909

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5509024

Dear Mr. Flack III:

The above facility was surveyed on August 31, 2015 through September 3, 2015 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, Health Regulation 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This

Adams Health Care Center September 17, 2015 Page 2

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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gary Nederhoff.

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,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

PRINTED: 09/26/2015

Minneso	ta Department of He	alth			FORM A	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00754	B. WING		09/03/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ADAMS	HEALTH CARE CENT	FR	T MAIN STRI MN 55909	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag ale number indicated below. In several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department witl	hearing on any assessments non-compliance with these tawritten request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa	participate in the electronic nsure orders consistent with		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned	oftware.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

obul.htm The State licensing orders are

delineated on the attached Minnesota

http://www.health.state.mn.us/divs/fpc/profinfo/inf

**Electronically Signed** 09/25/15

Minnesota state statutes/rules for Nursing

(X6) DATE

Homes. The assigned tag number appears in the far left column entitled "ID

TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00754	B. WING		09/0	3/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ADAMS	HEALTH CARE CENT	ER 810 WEST ADAMS, N	MAIN STRI IN 55909	EET		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
2 000	Department of Hearyou electronically. Is necessary for Star enter the word "corn text. You must then State licensure proceompletion date, the corrected prior to el Minnesota Departm On August 31, Sept surveyors of this Deabove provider and orders are issued.	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be ectronically submitting to the ent of Health. The separtment's staff, visited the the following correction Please indicate in your orrection that you have ers, and identify the date when	2 000	Prefix Tag." The state statute/rule compliance is listed in the "Summa Statement of Deficiencies" column replaces the "To Comply" portion of correction order. This column also includes the findings which are in the of the state statute after the statem. This Rule is not met as evidence following the surveyors findings as Suggested Method of Correction aperiod for Correction. PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION OF MINNESOTA ST STATUTES/RULES.	ary and of the violation nent, by." re the nd Time DING OF THIS ON FOR	
2 302	or related disorder to ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144.  (a) If a nursing facil Alzheimer's disease or related of segregated or generate staff and their supervisor care.  (b) Areas of require	EASE OR RELATED ING: .6503 ity serves persons with disorders, whether in a eral unit, the facility's direct rs must be trained in dementia	2 302			9/24/15

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00754	B. WING	B. WING		3/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/0	
ADAMS	HEALTH CARE CENT	FR	T MAIN STRI MN 55909	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 302	related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shal written or electronic training program, the trained, the frequer topics covered. (d) The facility shall this section.  This MN Requirem by: Based on interview facility failed to ensinformation regardidementia training, itraining program, the trained, the frequer topics covered in the	activities of daily living; with challenging behaviors;	2 302	Completed on 09/24/2015		
	all 41 residents and Findings include:					
	training program, the documentation that (resident families) was Alzheimer's training employees trained, basic topics covered					
	licensed social wor	on 9/3/15, at 1:37 p.m. ker (LSW)-A stated no facility dementia training is				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		00754	B. WING		09/0	3/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE			
ADAMS I	ADAMS HEALTH CARE CENTER  810 WES ADAMS			EET			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 302	Continued From pa	ge 3	2 302				
	provided to residen knowledge.	ts nor their families to her					
	administrator stated booklet available to information about d training, but it had g "[I] don't know wher Furthermore, no infincluded in the adm families when a restacility.  SUGGESTED MET The DON or design regarding staff train packet so consume information. The DO staff about this requensure compliance.	ormation on the training was ission packets provided to ident had been admitted to the THOD OF CORRECTION: the could add information ing to the resident admission ers were aware of this DN or designee could educate uirement and conduct audits to					
2 435	MN Rule 4658.0210 Assignments	) Subp. 2 A.B. Room	2 435			9/24/15	
	must develop and in procedures for addincluding complaint and roommates. A procedures must in A. a mechanism resolution of room complaints; and	complaints. A nursing home mplement written policies and dressing resident complaints, s regarding room assignments t a minimum, the policies and clude the following: n for informal dispute assignment and roommate for documenting the complaint					

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00754	B. WING		09/03/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ADAMS	HEALTH CARE CENT	ER 810 WEST	MAIN STRI MN 55909	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 435	Continued From pa	age 4	2 435			
	by: Based on interview facility failed to provroommate for 1 of 2 admission, transfer	ent is not met as evidenced, and document review, the vide adequate notice of a new 2 residents (R30) reviewed for r, and discharge.		Completed on 09'24/2015		
	Findings Include:					
	R30 had been interviewed on 8/31/15, at 6:44 p.m. at which time stated he has had roommate changes every couple of months and added he was not given notice when his current roommate moved into their shared room. Furthermore, R30 stated he would have liked to receive notice before his roommate(s) change.					
	licensed social work recent change in ro to locate any docur	on 9/1/15, at 2:46 p.m. ker (LSW)-A stated R30 had a commate, but she was unable mentation R30 had been eiving a new roommate prior to admission.				
	dated 8/2014, ident included, " All res when they will be re and added, "All re when a change in r	doommate Changes policy tified a procedure which sidents will be given notice eceiving a new roommate" esidents will be given notice roommate is to occur. Adams r will explain why the change in esary"				
	administrator or dea	THOD OF CORRECTION: The signee could review policies room changes, and in-service viding advanced notice of a				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00754	B. WING		09/0	3/2015
	PROVIDER OR SUPPLIER	FR 810 WEST	DRESS, CITY, S F MAIN STRI MN 55909	STATE, ZIP CODE EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 435	ensure compliance.	e or room; then audit to	2 435			
2 565	Plan of Care; Use Subp. 3. Use. A co	5 Subp. 3 Comprehensive omprehensive plan of care personnel involved in the	2 565			9/24/15
	by: The facility failed to interventions for fall 1 of 5 residents (R2 Findings include: R20's Admission Rediagnoses that include pression, demen muscular disuse at Minimum Data Set dated 7/17/15 state impairment. The M not steady when me and needed one petransfers and walking the last quarter she	ent is not met as evidenced ensure care planned prevention were followed for 20) reviewed for accidents.  ecord identified R20 had uded Alzheimer's disease, tia muscle weakness and rophy. R20's Quarterly (MDS) an assessment tool d R20 had severe cognitive IDS also indicated R20 was oving from seating to standing, rson to physically assist with ng. R20's MDS stated during had more than 2 falls without vith injury. Review of R20's		Completed on 09/24/2015		
	electronic medical r 4/28/15, 5/11, 15, 1	ntn injury. Heview of R20's record revealed falls on 7, & 27/2015, 6/10/15, 7/4/15, 18/18/15 a total of 10 falls				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00754	B. WING		09/0	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ADAMS	HEALTH CARE CENT	FR	T MAIN STRE MN 55909	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	since 4/28/15.  R20's Falls Care P had a history of fall deficiencies and wa limitations and inable device. The Car pl was unsteady and and did not use the assistance. An app to observe frequen area when out of both R20's Mobility Care R20 was limited in related to bone/car weakness, unstead history of falls. Appresident in room also On 9/2/15, at 7:09 a herself down the fa Assistant (NA)-C a about going to her wheelchair to her row When arriving at R R20's wheelchair fa R20's wheelchair at the room, R20 stoopush her locked who was informed of the intervened, assisting in her wheelch aware that R20 sel she was not to be I her room. NA-C st	lan, dated 7/21/15, stated R20 is related to cognitive as unaware of her physical bility to safely transfer without a an continued that R20's gait she continued to self-transfer is call light or ask for broach started 8/19/15, stated thy and place in supervised ed.  Plan, dated 7/21/15, indicated mobility and ability to transfer tilage disorder and generalized by gait, need for device and a broaches included do not leave one when in wheelchair.  a.m., R20 was propelling cility's West hallway. Nursing proached R20, talked to her room and pushed R20's boom in the North hallway.  20's room, NA-C positioned acing a television set, locked and left. As soon as NA-C left of up, turned, and attempted to neelchair backwards. NA-E es situation and quickly				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00754	B. WING		09/0	3/2015
	NAME OF PROVIDER OR SUPPLIER  ADAMS HEALTH CARE CENTER  STREET A 810 WES ADAMS,			STATE, ZIP CODE EET	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	shift and staff can gresident's care plan approach, "do not le her wheelchair" was "I'm sorry. I didn't k In an interview on 9 Director of Nursing changes are comm report sheet. The E 24-hour report sheet to it throughout their there is a verbal repshift, and staff lister In a review of the fadocumentation was 7/21/15 care plan c in her room in her w A copy of the 24-ho information on R20' was requested but I During an interview DON confirmed she the care plan changes sheets.  SUGGESTED MET The director of nurs in-service staff regainplement a reside to ensure compliance.	go online and look at each is. When the care plan eave R20 alone in her room in shown to NA-C, she stated, know."  1/3/15, at 9:52 a.m., the (DON) stated that care plan unicated to staff on a 24-hour DON stated staff look at the et during report and can refer r shift. The DON also stated bort at the beginning of each in to updates at that time.  1/3/15, at 9:52 a.m., the (DON) stated that care plan unicated to staff on a 24-hour DON stated staff look at the et during report and can refer r shift. The DON also stated bort at the beginning of each in to updates at that time.  1/3/15 at 11:18 a.m. the et did not see any reference to ge on the 24-hour report  1/4/15 CORRECTION:  1/5/16 OF CORRECTION:	2 565			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00754	B. WING		09/03/2015	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/0	70/2010
ADAMS	HEALTH CARE CENT	FR	T MAIN STRI MN 55909	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 8	2 830			
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General		2 830			9/24/15
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on ad preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the ain in bed or the resident in bed.				
	by: Based on observation review the facility for while smoking for 1 for smoking; failed interventions for 1 with chronic falls higrab bar for safe us with a grab rail attarepositioning and g to prevent misuse of to manufacturers reformed of 1 resident (R3) a sustaining an injury Findings include:	ent is not met as evidenced ion, interview, and document ailed to assess resident safety of 1 resident (R62) reviewed to implement care planned fall of 1 resident (R20) identified story; failed to securely attach se for 1 of 1 resident (R32) ched to bed and used for etting in and out of bed; failed of a wheeled walker according ecommendations which put 1 att moderate risk of falling and ot.		Completed on 09/24/2015		
	by: Based on observation review the facility for while smoking for 1 for smoking; failed interventions for 1 with chronic falls higrab bar for safe us with a grab rail attarepositioning and g to prevent misuse of 1 resident (R3) a sustaining an injury.  Findings include:  LACK OF SMOKIN SAFETY:	ion, interview, and document ailed to assess resident safety of 1 resident (R62) reviewed to implement care planned fall of 1 resident (R20) identified story; failed to securely attach se for 1 of 1 resident (R32) ched to bed and used for etting in and out of bed; failed of a wheeled walker according ecommendations which put 1 at moderate risk of falling and ot.		Completed on 09/24/2015		

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00754	B. WING		09/03/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ADAMS	HEALTH CARE CENT	FR	MAIN STRE	EET		
(V4) ID	SLIMMARV STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	- NI	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 9	2 830			
	obstructive chronic muscle weakness, disorder. R62 had a through Mower Cou On 8/31/15 at 1:15	p.m. R62 was observed in the				
	parking lot near the garage, sitting in her wheelchair, smoking a cigarette. R62 waived to surveyors as they walked into the facility.					
	Admission Minimum Data Set (MDS) an assessment tool dated 8/4/15 revealed R62 had a brief interview for mental status (BIMS) score of six; indicating severe impairment. MDS also revealed R62 required a one person physical assist with locomotion off unit requiring supervision oversight, encouragement, or cueing.					
	R62's care plan dated 8/10/15 read, "problem: cigarette smoking. Resident smokes cigarettes. Resident has been advised the facilities policy on smoking but continues to smoke despite education including the risks of smoking on health and safety. Goal: Resident will be free from injury r/t [related to] smoking."					
		ogress notes revealed eserved smoking on: 8/3/15, /15, and 8/30/15.				
	was interviewed req not supposed to be wearing a nicotine p medication]. With h remember what we director of nursing ( to her. If we catch h	9 p.m. social services (SS)-A garding R62 smoking. "She is smoking at all because she is patch [ a physician ordered er memory she doesn't have talked about. The (DON) has tried to explain that her smoking we redirect her don't let her finish her				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	00754	B. WING	<del></del>	09/	03/2015	
NAME OF PROVIDER OR SUPPLIER	R STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
ADAMS HEALTH CARE CEN	TFR	T MAIN STRE MN 55909	ET			
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
to safely smoke, "free facility. They be smoke free."  On 09/03/15 at 9:0 administrator were receiving a smok because we are a has been educate. She does still smoadminstrator were independently smoutside smoking as She has a patch [Immedication]. We has been smoking assessment compassessment compassessment compassessment will. Care Center is a sor use of smoking building B. No smaterials will be a Care Center's groexcept at the follo Gazebo area on monosmoking allow. Resident's will be social services."  LACK OF FOLLO INTERVENTION OF R20's Admission of diagnoses that incompassion, demender.	as asked if R62 was assessed No, because we are a smoke residents] are just supposed to 00 a.m. the DON and interviewed regarding R62 ing assessment, "No we did not smoke free facility. She [R62] do numerous times not smoke. If R62 is safe to looke, "I have never seen her into I can't answer that question. Nicotine prescription inducate her when we know she go. There was no smoking oldeted."  The Center Smoking Policy dated Procedure; A. Adams Health is moke-free facility. No smoking materials will be allowed in the smoking or use of smoking llowed on the Adams Health unds, including parking lots, wing locations. Employees: orth side of building Residents: and on grounds or premises. informed on admission by  WING PLAN OF CARE IN REGARDS TO					

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STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00754	B. WING		09/0	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ADAMS	HEALTH CARE CENT	FR	T MAIN STRE MN 55909	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Minimum Data Set R20 had severe co also indicated R20 from seating to start to physically assist R20's MDS stated more than 2 falls winjury. Review of Frevealed 10 falls frozo15.  On 9/2/15, at 7:09 herself down the fat Assistant (NA)-C at about going to her wheelchair to her row When arriving at R R20's wheelchair fat R20's wheelchair at the room, R20 stoop push her locked where was informed of the intervened, assisting R20's Falls Care Phad a history of fall deficiencies and was limitations and inable device. The care pwas unsteady and and did not use the assistance. An apple to observe frequent area when out of be R20's Mobility Care R20 was limited in related to bone/car weakness, unstead	(MDS) dated 7/17/15 stated gnitive impairment. The MDS was not steady when moving nding, and needed one person with transfers and walking. during the last quarter she had ithout injury and one fall with R20's electronic medical record om April 28, 2015 to August 18, a.m., R20 was propelling cility's West hallway. Nursing pproached R20, talked to her room and pushed R20's from in the North hallway. 20's room, NA-C positioned acing a television set, locked and left. As soon as NA-C left of up, turned, and attempted to neelchair backwards. NA-E e situation and quickly ag R20 to bed.  Ian, dated 7/21/15, stated R20 is related to cognitive as unaware of her physical polity to safely transfer without a plan continued that R20's gait she continued to self-transfer a call light or ask for proach started 8/19/15, stated tly and place in supervised				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
	00754		B. WING		00/0	2/201 <i>E</i>
					<u>  U9/U</u>	3/2015
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ADAMS	HEALTH CARE CENT	ER ADAMS, N	MAIN STRI IN 55909	EEI		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 12	2 830			
	resident in room ald	one when in wheelchair.				
	confirmed she took sitting in her wheeld aware that R20 self she was not to be let her room. NA-C state care plan updates it shift and staff can gresident's care plan approach, "do not let aware that the staff can gresident's care plan approach, "do not let aware the staff can gresident's care plan approach, "do not let aware that the staff can gresident's care plan approach,"	N/2/15, at 8:45 a.m., NA-C R20 to her room and left her chair. NA-C stated she was f-transfers, but denied knowing eft alone in her wheelchair in ated that she learns about in report at the start of each go online and look at each is. When the care plan eave R20 alone in her room in as shown to NA-C, she stated, know."				
	Director of Nursing changes are comm report sheet. The E 24-hour report sheet to it throughout their there is a verbal repshift, and staff lister. In a review of the fadocumentation was	n/3/15, at 9:52 a.m., the (DON) stated that care plan unicated to staff on a 24-hour DON stated staff look at the et during report and can refer r shift. The DON also stated port at the beginning of each in to updates at that time.				
	7/21/15 care plan change to not leave R20 alone in her room in her wheelchair.					
		ur report sheet with 's 7/21/15 care plan change not received.				
	confirmed she did r	0/3/15, at 11:18 a.m., the DON not see any reference to the the 24-hour report sheets.				
	LACK OF SECURE RESIDENT SAFET	ED GRAB BARS FOR Y WITH USE:				

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STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00754	B. WING		09/0	3/2015
NAME OF I				STATE ZID CODE	09/0	3/2013
	PROVIDER OR SUPPLIER	810 WEST	MAIN STRE	STATE, ZIP CODE FFT		
ADAMS	HEALTH CARE CENT	ER ADAMS, N	_			
(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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	R32's Admission Reincluding dementia, R32's Annual Minir 7/10/15, indicated F cognition, required mobility and transfer moving from sitting Care Plan indicated generalized weakneand rib fractures remobility, transfers a approach dated 7/2 physical assist of 1-transfers; R32's con are to use an EZ statement of the company of the compan	ecord indicated diagnoses osteoporosis, and pain. num Data Set (MDS), dated R32 had severely impaired extensive assistance for bed ers and was unsteady when to standing. R32's Mobility I impaired mobility related to ess, history of left hip fracture quiring assistance with bed and wheelchair locomotion. An e2/15, directs staff to provide e2 staff with bed mobility and mpliance varies as and staff and for transfers  p.m., the right hand grab bar to be easily moved from side y attached to bed frame.  1/2/15, at 7:41 a.m., Nursing ated she would tell the f she found a loose grab bar. utinely takes care of R32.  1/2/15, at 8:02 a.m., for (MD)-A stated staff put lip board that is kept at the D-A stated he checks the clip has not received any requests D-A was asked to check R32's finding it loose, MD-A stated, ghten that up."	2 830			
		32 occasionally uses the grab e of the bed, as part of				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00754	B. WING		09/	03/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
ADAMS	HEALTH CARE CENT	810 WES	T MAIN STRE	ET		
ADAMS,			MN 55909			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 14	2 830			
	transferring out of b	ped.				
		as requested and received; address maintenance or grab bars.				
	MOBILITY DEVICE	USED INCORRECTLY:				
	7/16/15, identified F	num Data Set (MDS) dated R3 had moderate cognitive ed a walker for mobility.				
	was seated on a No in the hallway of the around the hallway while her arms were resting on the hand holding onto the de motion. When obse R3 was again seate four wheeled walke shop conversing wiproceeded to whee towards the dining wheeled walker. Rand was not holding	on 8/31/15, at 2:34 p.m. R3 ova brand four wheeled walker on North Unit. R3 wheeled while seated on the device of crossed with her elbows les of the device. R3 was not vice for security when in erved on 9/1/15, at 9:27 a.m. and on the seat portion of her r in the doorway of the beauty the other residents. R3 I herself down the hallway from while seated on the four 3 again had her arms crossed gent on the walker for security.				
	licensed practical n on her four wheele around "quite often educate her on safe moderate cognitive but it hadn't help an LPN-D stated she w wheeled walkers m this practice, but and do because "She [F	on 9/2/15, at 12:59 p.m. urse (LPN)-D stated R3 sits d walker and pushes herself." The staff had tried to e use of walker, despite her impairment, on not doing so, at R3 continued to do it. was unaware of what the four anufacturer advised regarding ided she felt it was unsafe to R3] can easily fall" off the motion. Further, LPN-D				

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-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00754	B. WING	····	09/0	3/2015
	PROVIDER OR SUPPLIER	810 WEST	DRESS, CITY, S	STATE, ZIP CODE EET		
ADAMS	HEALTH CARE CENT	ER ADAMS, N	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 15	2 830			
	had a label fixed to use as a wheelchai someonelock har seated."	d brakes when sitting or while				
	director of nursing ( reminding R3 that it around while seated dangerous." Further therapy should of b	9/2/15, at 1:15 p.m. the DON) stated staff should be is unsafe to move herself d on the walker "because its ermore, the DON added, een contacted and an ave been completed for R3's				
	read, "Safety Warni included, "DO NOT	colling Walker User Guide ng Instructions" which use as a wheelchair or to ', and, "DO NOT self propel or seated."				
	director of nursing (review the facility poresident smoking, a changes to reflect of The DON could insert devices only as directions, and abimplement a reside could then audit the	HOD OF CORRECTION: The DON) or designee could plicy for assessment of and make any needed current regulations for safety. Service staff on using mobility ected by the manufacturer yout how to correctly into plan of care. The DON isse to ensure compliance.				
	(21) days.	R CORRECTION: Twenty-one				
2 900	MN Rule 4658.0529 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			9/24/15
	Subp. 3. Pressure	sores. Based on the				

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Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00754	B. WING		09/0	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
ADAMS HEALTH CARE CENTER			MAIN STRI IN 55909	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	comprehensive res of nursing services development of a n provides that:  A. a resident whe without pressure sores unle condition demonstrate authenticates, that is a resident who receives necessary promote healing, promote heal	ident assessment, the director must coordinate the ursing care plan which  o enters the nursing home pres does not develop east the individual's clinical ates, and a physician they were unavoidable; and the has pressure sores of treatment and services to revent infection, and prevent	2 900	Completed on 09/24/2015		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00754	B. WING		09/0	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ADAMS	HEALTH CARE CENT	FR	MAIN STRE	ET		
	T	ADAMS, I	MN 55909			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU! CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 17	2 900			
2 000	prominences." R57 For Predicting Pres assessment dated "AT RISK" of pressinot identify R57 to hime.  R57's progress note R57 "c/o [complaine was redhe [R57] nursing home he habreak down." An and nine days late a identified an, "Asseblanchable redness	7's most recent Braden Scale sure Sore (ulcer) Risk 7/29/15, identified R57 to be ure ulcer development, but did nave any current ulcers at the es dated 7/11/15, identified ed of] pain in coccyx and it wants an air bedin other ad air bed and he did not dditional note dated 7/20/15 after 7/11/15 progress note, essed sacral area has some s has prominent bony				
	prominences me [centimeters] X [by] added, "Will call MI dressing to protect However, the noted immediate intervent pressure ulcer deveroistated 7/25/15 and 14 day the developed red dated 7/11/15, prog "complained of st couple of red areas of nickels." No furti	asures approximately 5 cm 5 cm." The progress note D [medical doctor] for order for area from skin breakdown." I did not identify any tions to reduce R57's risk of elopment. Furthermore, on s after initial identification of ess found in progress note ress note identified, inging on lower backnoted a on lower spine about the size her progress notes identified assessment of R57's newly				
	any interventions to risk of worsening or development.  During interview on stated he still had resacrum as it was the R57 stated he development.	on his sacrum and spine, nor be out in place to reduce the new pressure ulcer  9/1/15, at 2:55 p.m. R57 edness on his spine and e "bony part" of his buttocks. elops redness on his sacrum				
		e to time", and was applying ns from his bedside table to				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00754	B. WING		09/0	3/2015
	PROVIDER OR SUPPLIER HEALTH CARE CENT	810 WEST	DRESS, CITY, S F MAIN STRE MN 55909	TATE, ZIP CODE E <b>ET</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	them when he note added he had requiplaced on his bed to of pressure ulcer de [facility] didn't have  R57's care plan dat "at risk for pressure nutrition and friction having his skin remot identify R57 to pressure ulcers.  When interviewed assistant (NA)-G stindependent" with his pressure ulcers that During interview on registered nurse (Rourrent pressure ulcon his buttocks and R57 would request developed red area encouraged him to  When interviewed of director of nursing unaware of any deviacrum or spine, and anything reported to unaware R57 had riskin breakdown and DON she said, "The During observation 9/2/15, at 8:45 a.m. viewed R57's sacruarea of redness on	d them. Further more, R57 ested to have an air mattress o reduce the redness and risk evelopment, but was told "they	2 900			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00754	B. WING		09/0	3/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ADAMS HEALTH CARE CENTER 810 WEST ADAMS, M		Г MAIN STRI MN 55909	EET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	non-blanchable red measured at "three [centimeters]", alon vertebrae (spine) wo pushed on. The Doair bed in place to rulcer development to breakdown." Fur had not been comporessure ulcer risk Scale (7/29/15) as developing these a and spine. On 9/3/3 stated she had compore and had been told application of skin in the DON stated she record and R57 had pressure ulcer deveredness on his sactit, but added, R57 re-assessed.  An undated facility Prevention and Tre read, "It is the policy assess residents wo increase the risk for to implement prevention and the policy directed and th	Iness which the DON by two and a half g with some red areas on his chich were blanchable when DN stated R57 should have an educe his risk of pressure as he "definitely has potential rther, The DON stated R57 brehensively re-assessed for since the most recent Braden she was not aware R57 was reas of redness on his sacrum 15, at 9:04 a.m. the DON sulted with a wound nurse, R57 should have a daily repair cream. Furthermore, the reviewed R57's medical d not been re-assessed for elopment since developing the rum and spine, "I do not see should have been  Policy and Procedure for the atment of Skin Breakdown y to properly identify and hose clinical conditions r impaired skin integrity [and] intative measures" Further, staff to complete a valuation of Skin Risk Factors"	2 900			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00754	B. WING		09/0	3/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ADAMS	HEALTH CARE CENT	ER 810 WEST	ΓMAIN STRI ⁄IN 55909	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 20	2 900			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 910	MN Rule 4658.0528 Incontinence	5 Subp. 5 A.B Rehab -	2 910			9/24/15
	have a continuous programment to recomprehensive results home must ensure A. a resident without an indwellinunless the resident that catheterization B. a resident where event urinary traces.	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: ho enters a nursing home ag catheter is not catheterized is clinical condition indicates was necessary; and no is incontinent of bladder e treatment and services to infections and to restore as er function as possible.				
	by: Based on observati review, the facility for reassess 1 of 3 res urinary incontinence continence function Findings include: R3's admission Min 4/15/15, indicated Fimpairment, was all	ent is not met as evidenced on, interview and document ailed to comprehensively idents (R3) reviewed for e and had a change in i.  simum Data Set (MDS) dated R3 had moderate cognitive ways continent of urine and ting program. A review of R3's		Completed on 09/24/2015		

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00754	B. WING		09/0	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ADAMS	HEALTH CARE CENT	ER 810 WEST	MAIN STRE	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 21	2 910			
	resident had model impairment, was or and had no urinary R3's current care p as being continent	lan dated 8/6/15, identified R3 of bladder. The target goal for				
	next review. Interve were to have episo	entinent of bladder through the entions that were put in place des of incontinence reported art in the point of care a ing program.				
		ladder Assessment, dated hat R3 was continent of				
	The facility Nursing Assistant Point of Care Bladder Category Report worksheet (what the nursing assistants use to document cares to residents) reviewed from 6/18/15 through 9/3/15 indicated that R3 had thirty-six episodes of urinary incontinence.					
	Nursing Assistant (	on 9/2/15, at 9:32 a.m., NA)-E stated that he change R3's bedding due to				
	stated that she soils least half the time p stated that she had whenever her bedd be changed. R3 sta	on 9/2/15, at 1:47 p.m., R3 sher underwear with urine at prior to going to the toilet. She told the nurse in the past ing was soiled and needed to ated that her urinary ened mostly at night but the day.				
		on 9/3/15, at 9:49 a.m., urse (LPN)- B, stated that the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00754	B. WING		09/	03/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
ADAMS	HEALTH CARE CENT	FR	T MAIN STRE MN 55909	ΈΤ		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 910	nursing staff any instated that she is not R3's urinary incontinuated that she did incontinence this may reported to the licer.  When interviewed to birector of Nursing not aware that the rurinary incontinence resident had episod is something that stated that the have notified the nushe would have expected to have been done of urinary incontinence.  When interviewed to stated that if a residincontinence she we computerized chart. She stated that if a residincontinence where that needed to be computed to the following that the date.  After review of the followed and Bowel Assessing dated 9/22/15, it standams Health Care.	are supposed to report to the stances of incontinence. She of aware of ever being told of mence episodes.  on 9/3/15, at 11:13 a.m., R3 have an episode of urinary orning. However, this was not need nurse by NA's.  on 9/3/15, at 1:23 p.m., the (DON) stated that she was resident had episodes of e. She stated that if the des of urinary incontinence that raff should report right away. nursing assistants should ursing staff. She stated that bected a bladder assessment if the resident had an episode nce.  on 9/3/15, at 1:51 p.m., NA-F dent had an episode of urinary ould first document it in the and then let the nurse know. It is did notice at least one time an episode of urinary of the resident had soiled pants hanged but no could not	2 910	DEFICIENCY)		
	bladder and /or bov given the opportuni	wel is identified and assessed, ty to achieve continence or rmal bladder and/or bowel				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00754	B. WING		09/0	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ADAMS	HEALTH CARE CENT	ER 810 WEST ADAMS, N	MAIN STRE	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 23	2 910			
	Assessment will be significant change i SUGGESTED MET director of nursing (review the facility pridentified incontiner to reflect current restaff regarding the The DON could the	e. A Bladder and Bowel completed annually or if a n continent status is identified.  THOD OF CORRECTION: The DON) or designee could olicy and procedure for newlynce, make necessary changes gulations, and then in-service facility policy and procedure(s). In audit to ensure compliance.  R CORRECTION: Twenty-one				
21530	MN Rule 4658.1310	A.B.C Drug Regimen Review	21530			9/18/15
	reviewed at least m currently licensed by This review must be Appendix N of the Surveyor Procedure Requirements in Lot the Department of I Health Care Finance This standard is in available through the system. It is not sue B. The pharma irregularities to the and the attending pomust be acted upor physician visit, or sepharmacist. For purpon' means the acreport and the significant of nursing services	en of each resident must be onthly by a pharmacist y the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, sing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan bject to frequent change. cist must report any director of nursing services hysician, and these reports in by the time of the next coner, if indicated by the proses of this part, "acted acceptance or rejection of the ng or initialing by the director and the attending physician. ing physician does not concur				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00754	B. WING		09/0	3/2015
	PROVIDER OR SUPPLIER HEALTH CARE CENT	810 WEST	MAIN STR	STATE, ZIP CODE EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21530	with the pharmacist not provide adequal pharmacist believes being adversely afferefer the matter to tif the medical direct physician. If the methe attending physician does not must be referred for assessment and as by part 4658.0070. The medical direct must refer the matter assessment and as the medical direct must refer the matter as the medical dir	It's recommendation, or does the justification, and the set the resident's quality of life is ected, the pharmacist must the medical director for review tor is not the attending edical director determines that clian does not have adequate order and if the attending change the order, the matter or review to the quality esurance committee required. If the attending physician is for, the consulting pharmacist er directly to the quality esurance committee.  The attending physician is for the consulting pharmacist er directly to the quality esurance committee.  The attending physician is for the current is not met as evidenced and document review, the consulting pharmacist enditions from a psychiatric endations from a psychiatric enditions.  The attending to the current it is according to the current	21530	Completed on 09/18/2015		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00754	B. WING	<del></del>	09/0	3/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ADAMS	HEALTH CARE CENT	FK	T MAIN STRI MN 55909	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21530	upon asking for it's psychiatrist to the father referral form from the referral form from the referral form from the referral form from the diagnosis of cognition on 7/6/15 a psychiat completed. Review "From a medication treated with clonaxing as causing paradox exacerbating anxies the risk of falls signic circumstances, mindication would be used, starting the diagnosis of problem noticed at night and the current dose of helpful, hence this acconsideration." "From assessment perspegradually tapering the current total 4 mg and 4 weeks completely anxiety remains an and treatment is necessing quetiapine [antipsychological for the current dose of helpful, hence this acconsideration." "From the current total 4 mg and 4 weeks completely anxiety remains and treatment is necessing quetiapine [antipsychological for the commendations of the reference of the problem of the p	location it was faxed from the acility on 9/3/15. Review of om the appointment read, orgitive testing, although R12 us well at all. Will attempt is more alert." A new ve disorder was identified.  atric evaluation was of the final report identified: a perspective, he is being epam 1 mg 2 times a day and denzodiazepines in dementia groblems cognitively as well cical agitation and ty. In addition, it also elevates ificantly. Under the tazapine [antidepressant on the antideal medication to be oses of 7.5 mg, increasing it 30 mg as needed to help with the anxiety. I understand that a atic behaviors have being a based on current evidence, clonazepam is not being should be an appropriate of an anxiety/cognitive risk ective, i would recommend a he clonazepam from the aday over a period of the next of and stopped. In its place if issue and symptomatic sary, then small doses of chotic medication] at 12.5 to	21530			

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STATEMENT OF DEFICIENCIES (X1) PROVIDI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
		00754	B. WING		09/0	3/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•		
ADAMS	HEALTH CARE CENT	ER 810 WEST ADAMS, N	MAIN STRI IN 55909	EET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE	
21530	was not scanned in been. LPN-A stated referral back she she she stated apparer didn't get addressed report) was at the consequested it be faxed have it to determine medication regimer. A policy regarding conone provided.  SUGGESTED MET director of nursing (in-service the consistimely identification irregularities.	to the facility and should have d if the nurse didn't get the nould have called to get it. atly no one called about it so it d. She stated, this (the final linic and she had just ed to them, the facility did not e what changes to R12	21530				
21535	Subpart 1. General must be free from unnecessary drug in A. in excessive therapy; B. for excessive therapy; B. for excessive therapy; C. without adec D. in the prese which indicate the odiscontinued. In addition to the dipart 4658.1310, the with provisions in the	al. A resident's drug regimen unnecessary drugs. An s any drug when used: dose, including duplicate drug	21535			9/24/15	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00754	B. WING		09/0	3/2015
	PROVIDER OR SUPPLIER HEALTH CARE CENT	810 WEST	MAIN STRI	STATE, ZIP CODE EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	Continued From pa  483.25 (1) found in Operations Manual Long-Term Care Fa Department of Hea Health Care Financ This standard is inc available through th system and the Sta subject to frequent  This MN Requireme by: Based on observati review, the facility fa adverse consequer while wearing a nice (R62) who was on a which included a nic smoke even though warning in regards patch and failed to from a psychiatric e residents (R12) rev medications.  Findings include:  LACK OF ASSESS ADVERSE AFFECT	ge 27  Appendix P of the State Guidance to Surveyors for cilities, published by the th and Human Services, ing Administration, April 1992. orporated by reference. It is the Minitex interlibrary loan the Law Library. It is not	21535			
	diagnoses to includ obstructive chronic muscle weakness,	o the facility on 7/28/15 with e: acute respiratory failure, airway, difficulty in walking, memory loss, and tobacco use guardian appointed to her inty.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00754	B. WING	<del></del>	09/0	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ADAMS	HEALTH CARE CENT	FR	T MAIN STRE MN 55909	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21535	On 8/31/15 at 1:15 parking lot near the wheelchair, smokin surveyors as they we Review of R62's Ma Record (MAR) reversations at day. Remove patch; 21 mcg/24, at time a day. Remove patch on." R62's Madministered the nitthrough 9/2/15.  Admission Minimum assessment tool dabrief interview for maix; indicating sever R62's care plan data cigarette smoking. Resident has been smoking but continued ucation including health and safety. Containing the series of R62's proportion of R62 ob 8/6/15, 8/9/15, 8/17. Furthermore, there documented nor proportion of R62 ob 8/6/15, 8/9/15, 8/17. Furthermore, there documented nor proportion of R62 ob 8/6/15, 8/9/15, 8/17. Furthermore, there documented nor proportion of R62 ob 8/6/15, 8/9/15, 8/17. Furthermore, there documented nor proportion of R62 ob 8/6/15, 8/9/15, 8/17. Furthermore, there documented nor proportion of R62 ob 8/6/15, 8/9/15, 8/17. Furthermore, there documented nor proportion of R62 ob 8/6/15, 8/9/15, 8/17. Furthermore, there documented nor proportion of R62 ob 8/6/15, 8/9/15, 8/17. Furthermore, there documented nor proportion of R62 ob 8/6/15, 8/9/15, 8/17. Furthermore, there documented nor proportion of R62 ob 8/6/15, 8/9/15, 8/17. Furthermore, there documented nor proportion of R62 ob 8/6/15, 8/9/15, 8/17. Furthermore, there documented nor proportion of R62 ob 8/6/15, 8/9/15, 8/17.	p.m. R62 was observed in the garage, sitting in her g a cigarette. R62 waived to valked into the facility.  Redication Administration aled an order for "nicotine apply patch transdermally one e old patch before placing new AR indicated R62 was cotine patch daily 8/1/15  In Data Set (MDS) an ted 8/4/15 revealed R62 had a rental status (BIMS) score of re impairment.  Resident smokes cigarettes. advised the facilities policy on ues to smoke despite the risks of smoking on Goal: Resident will be from smoking."  Digress notes revealed served smoking on: 8/3/15, and 8/30/15.		DEFICIENCY)		
	because she is wea	upposed to be smoking at all aring a nicotine patch. With her 't remember what we have				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00754	B. WING		09/0	3/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 00/0	0,2010
ADAMS	HEALTH CARE CENT	ER 810 WEST ADAMS, N	MAIN STRI	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
21535	Continued From page 29		21535			
	explain that to her.	lirector of nursing has tried to If we catch her smoking we facility and don't let her finish				
	(DON) stated R62 not know if the nico	.m. the director of nursing wore a nicotine patch but did tine patch was removed when have been smoking.				
	Administration, date you continue to smuse nicotine gum, on nicotine containing product do not smoopatch. The nicotine	nings from the Food and Drug ed 1/2010 read, "Do not use if oke, chew tobacco, use snuff, or use another patch or other productsWhen using this oke even when not wearing the in your skin will still be tream for several hours after ch."				
		ctions include"stop smoking ou being using the patch."				
	LACK OF TIMELY I FOLLOWING PSYC RECOMMENDATION					
	physician orders R <sup>-</sup> with diagnosis inclu The physician orde receiving the medical (antianxiety medical)	itted according to the current 12 was admitted to the facility ding anxiety and insomnia. rs also identified R12 as ations clonazepam and Trazodone dication used for insomnia).				
	physician due to inc and an evaluation v There was no evalu	ation was ordered by the creased anxiety and behaviors was attempted on 5/28/15. Justion found in the record and location it was faxed from the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00754	B. WING		09/0	3/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ADAMS	HEALTH CARE CENT	FR	T MAIN STRE MN 55909	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21535	psychiatrist to the fithe referral form from the diagnosis of cognition of the diagnosis of cognition of the diagnosis of cognition of the completed. Review "From a medication treated with clonazing at bedtime. End the cample can be complicating as causing paradox exacerbating anxies the risk of falls signification of the complete of th	acility on 9/3/15. Review of om the appointment read, orgnitive testing, although R12 us well at all. Will attempt is more alert." A new live disorder was identified.  atric evaluation was wo of the final report identified: a perspective, he is being epam 1 mg 2 times a day and Benzodiazepines in dementia g problems cognitively as well exical agitation and ty. In addition, it also elevates difficantly. Under the tazapine [antidepressant doe an ideal medication to be loses of 7.5 mg, increasing it 30 mg as needed to help with the anxiety. I understand that a atic behaviors have being disased on current evidence, clonazepam is not being should be an appropriate of an anxiety/cognitive risk ective, i would recommend a the clonazepam from the aday over a period of the next y and stopped. In its place if issue and symptomatic sary, then small doses of chotic medication] at 12.5 to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00754	B. WING		09/03/2015		
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
ADAMS	HEALTH CARE CENT	ER 810 WEST ADAMS, N	MAIN STRI MN 55909	EET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE	
21535	been. LPN-A stated referral back she si She stated apparer didn't get addressed report) was at the confidence of the factor of t	d if the nurse didn't get the nould have called to get it. atly no one called about it so it d. She stated, this (the final linic and she had just ed to them, the facility did not e what changes to R12 in needed changing.  CONSULT WAS requested and THOD OF CORRECTION: sing (DON) or designee could rding the implementation of commendations with respect dications. The DON could	21535				
21665	A nursing home must functional, comforts environment, allowing personal belonging.  This MN Requirements: Based on observation failed to ensure the to maintain a sanital 17 out of 23 bathrous 107, 108, 109, 112,	O Physical Environment  Just provide a safe, clean, able, and homelike physical ing the resident to use is to the extent possible.  Lent is not met as evidenced on & interview, the facility exhaust vents were cleaned any bathroom environment in the common management of the common management in t	21665	Completed on 09/24/2015		9/24/15	

AND PLAN OF CORRECTION IDENTIFICATION NOMBER. A. BUILDING:	E SURVEY PLETED			
00754 B. WING 09/03.	3/2015			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	72013			
ADAMS HEALTH CARE CENTER  810 WEST MAIN STREET  ADAMS, MN 55909				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE			
21665 Continued From page 32 21665				
Findings Include:  Upon entrance to the facility on 8/31/15 the resident bathroom in room 128 was observed to have visible heavy dust present on the vent grille cover and on the grille inside the vent. Upon further investigation on 9/1/15 revealed 17 out of 23 resident bathrooms in rooms 101, 102, 103, 105, 106, 107, 108, 109, 112, 114, 124, 125, 126, 128, 129, 131, and 135 to have heavy surface dust on vent grille covers and on the grille inside the vent. The surface dust was visible from the doorway of the bathroom.  On 9/1/15 at 2:41 p.m. the housekeeping supervisor was asked about cleaning the air vents, she stated, "They get cleaned every Monday. Take a broom or feather duster to the vents. And then maintenance will take off the cover and go internally." The housekeeping supervisor then walked with surveyor to the bathroom in room 101 where she verified the vents were not clean and had not been cleaned according to the schedule on Monday cleaning.  On 9/3/15 at 9:21 a.m. the maintenance (M)-Z worker was asked about cleaning the air vents in resident bathrooms, he stated; "I take them [air vent grills] down, spray them down with cleaner and then power wash them twice a year." The maintenance worker then walked with surveyor to the bathroom in room 105 where he verified the vent grille cover was covered in a thick layer of dust and needed to be cleaned.  Resident Room Cleaning Schedule, undated read, "Monday, Clean bathroom vents, dust under TV, mop out linen rooms floors, dust light				

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` '			DATE SURVEY COMPLETED	
JAMES I BANGI GOTTILOTION			A. BUILDING:				
		00754	B. WING		09/03/2		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
ADAMS HEALTH CARE CENTER  810 WEST MAIN STREET  ADAMS, MN 55909							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
21665	Continued From pa	ge 33	21665				
	1/15/15 read, "Each take a duster and condition Adams Health Care when done. Bi-Ann by maintenance de good and repainted vacuumed out at the SUGGESTED MET The director of main review all side rails proper fitment and	THOD OF CORRECTION: Intenance or designee could and/or grab bars to ensure review all bathrooms on an oroper cleaning then audit to					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			9/24/15	
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a					
	by: Based on observative review, the facility for (R15) observed durassistance was treated.	ent is not met as evidenced on, interview and document ailed to ensure 1 of 1 resident ring activities of daily living ated in a dignified manner with verbal conversation.		Completed on 09/24/2015			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE SURVEY COMPLETED	
		00754			00/0	0.1004.5	
		00754			09/0	3/2015	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S <b>I MAIN STRI</b>	STATE, ZIP CODE EET			
ADAMS	HEALTH CARE CENT	ER ADAMS, N					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21805	5 Continued From page 34		21805				
	Findings include:						
	diagnoses that incluosteoporosis. The indicated R15 was a twice a day and Tra a day for pain relative remission. R15's A Minimum Data Set indicated R15 had s R15's Cognitive Los directed staff to provindependent decisic clothes to wear." R (ADL) Functional R plan indicated that I related to generalize to perform ADLs includirected staff to phywith grooming/hygic weekly bath.  On 9/2/15, at 9:14 a closet, near her door garment. Nursing A and, in a sharp tone want to put on a ho NA-D pulled the pin and stated to R15, over 80 outside!" Nutimes during the interview on the put on the pin and stated to R15, over 80 outside!" Nutimes during the interview on the put on t	der Report indicated R15 had uded dementia and Physician Order Report also on acetaminophen (analgesic) amadol (analgesic) three times ing to multiple myeloma, in Admission assessment (MDS), dated 6/17/15 severely impaired cognition. Ses/Dementia Care Plan ovide opportunities of on making, "i.e. choosing R15's Activities of Daily Living ehabilitation Potential Care R15 had a self-care deficient ed weakness and was unable dependently. R15's care plan ysically assist R15 one-on-one ene, dressing, toileting and a.m., R15 was in front of her proway, pointing to a pink Assistant (NA)-D approached ender of voice, told R15 she didn't susecoat, it was after breakfast. In the garment out of the closet "Oh, it's a sweater. But it's A-D referred to R15 several eraction as "Hun." As NA-D at R15's right arm into the pink et R15's left arm up and a sarm into the sleeve. R15 Oh!, is there anyone else					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00754	B. WING	<del></del>	09/0	3/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRE				STATE, ZIP CODE		
ADAMS HEALTH CARE CENTER 810 WEST M ADAMS, MN				EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 35	21805			
	twice a month (this	ets pulled to the floor at least was one of the times pulled to cares) and that is just part of				
	Administrator and D Administrator stated	0/3/15, at 1:48 p.m., the Director of Nursing, the d that if a resident wants a what should be done for the				
	A policy on staff bur received from the fa	rnout was requested but not acility.				
	Quality of Life & Dig residents shall be tr at all times. The po respectfully to resid	ned policy was received on gnity which stated that reated with dignity and respect plicy read, "Staff shall speak lent at all times, including dent by his or her name of				
	director of nursing of	THOD OF CORRECTION: The or designee could in-service sectful interaction with staff and e compliance.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				