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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: SG3J

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00754

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245509**
2.STATE VENDOR OR MEDICAID NO.
(L2) **015540300**

3. NAME AND ADDRESS OF FACILITY
(L3) **ADAMS HEALTH CARE CENTER**
(L4) **810 WEST MAIN STREET**
(L5) **ADAMS, MN** (L6) **55909**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/19/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 11/02/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/04/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245509	A. Building B. Wing	10/19/2015

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) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **09/24/2015**	ID Prefix **F0247** Reg. # **483.15(e)(2)** LSC	Correction Completed **09/24/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/24/2015**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **09/24/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **09/24/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/24/2015**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **09/24/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **09/18/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **09/24/2015**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **09/24/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/kfd	11/04/2014	10160	10/19/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 9/3/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245509	A. Building B. Wing 01 - MAIN BUILDING 01	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) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0054	Correction Completed 10/05/2015	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 09/24/2015	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By TL/kfd	Date: 11/02/2015	Signature of Surveyor: 25822	Date: 10/24/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 9/2/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: SG3J

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00754

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245509**
2.STATE VENDOR OR MEDICAID NO.
(L2) **015540300**

3. NAME AND ADDRESS OF FACILITY
(L3) **ADAMS HEALTH CARE CENTER**
(L4) **810 WEST MAIN STREET**
(L5) **ADAMS, MN** (L6) **55909**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/03/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Austin Fry, HFE NE II 09/262015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/09/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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:

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

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

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

<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.

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

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

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

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

Mr. 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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245509	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS HEALTH CARE CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R15) observed during activities of daily living assistance was treated in a dignified manner with physical cares and verbal conversation. Findings include: R15's Physician Order Report indicated R15 had diagnoses that included dementia and osteoporosis. The Physician Order Report also indicated R15 was on acetaminophen (analgesic) twice a day and Tramadol (analgesic) three times	F 241	R15 is treated in a dignified manner with physical cares and verbal communication. All residents of Adams Health Care Center will be treated in a dignified manner with physical cares and verbal communication. Nursing staff in-serviced on respectful interaction with residents on September 24, 2015. DON and/or her designee will monitor daily for a week, once per week for 2 weeks and once per month for 3 months. Results will be reviewed by QA/QI	9/24/15

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

Electronically Signed | 09/25/2015

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	245509	A. BUILDING _____ B. WING _____	09/03/2015

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F 241	Continued From page 1 a day for pain relating to multiple myeloma, in remission. R15's Admission assessment Minimum Data Set (MDS), dated 6/17/15 indicated R15 had severely impaired cognition. R15's Cognitive Loss/Dementia Care Plan directed staff to provide opportunities of independent decision making, "i.e. choosing clothes to wear." R15's Activities of Daily Living (ADL) Functional Rehabilitation Potential Care plan indicated that R15 had a self-care deficient related to generalized weakness and was unable to perform ADLs independently. R15's care plan directed staff to physically assist R15 one-on-one with grooming/hygiene, dressing, toileting and weekly bath. On 9/2/15, at 9:14 a.m., R15 was in front of her closet, near her doorway, pointing to a pink garment. Nursing Assistant (NA)-D approached and, in a sharp tone of voice, told R15 she didn't want to put on a housecoat, it was after breakfast. NA-D pulled the pink garment out of the closet and stated to R15, "Oh, it's a sweater. But it's over 80 outside!" NA-D referred to R15 several times during the interaction as "Hun." As NA-D was talking, she put R15's right arm into the pink top. NA-D then lifted R15's left arm up and quickly thrust R15's arm into the sleeve. R15 immediately said, "Oh!, is there anyone else working here? " In an interview on 9/2/15, at 1:35 p.m., NA-D stated that she is designated as a functional mobility staff, and gets pulled to the floor at least twice a month (this was one of the times pulled to help residents with cares) and that is just part of the job. In an interview on 9/3/15, at 1:48 p.m., the	F 241	Committee for further recommendations.	

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F 241	Continued From page 2 Administrator and Director of Nursing, the Administrator stated that if a resident wants a sweater on, that is what should be done for the resident. A policy on staff burnout was requested but not received from the facility. An undated, unsigned policy was received on Quality of Life & Dignity which stated that residents shall be treated with dignity and respect at all times. The policy read, "Staff shall speak respectfully to resident at all times, including addressing the resident by his or her name of choice."	F 241		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to provide adequate notice of a new roommate for 1 of 2 residents (R30) reviewed for admission, transfer, and discharge. 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	F 247	R30 will receive notice of roommate change every time there is such change. All residents of Adams Health Care Center will receive notice of roommate change per facility policy when they will be receiving a new roommate and when a change in roommate is to occur. Nursing staff and Social Services in-serviced regarding providing advanced notice of a change in roommate or room. Policy and Procedure for room changes reviewed. Administrator, Social Services and or their	9/24/15

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F 247	Continued From page 3 before his roommate(s) change. When interviewed on 9/1/15, at 2:46 p.m. licensed social worker (LSW)-A stated R30 had a recent change in roommate, but she was unable to locate any documentation R30 had been notified he was receiving a new roommate prior to the new resident's admission. A facility Room & Roommate Changes policy dated 8/2014, identified a procedure which included, "... All residents will be given notice when they will be receiving a new roommate..." and added, "...All residents will be given notice when a change in roommate is to occur. Adams Health Care Center will explain why the change in roommate is necessary..."	F 247	designee will audit once per week for 1 month and once per month for 3 months to monitor for compliance.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: The facility failed to ensure care planned interventions for fall prevention were followed for 1 of 5 residents (R20) reviewed for accidents. Findings include: R20's Admission Record identified R20 had diagnoses that included Alzheimer's disease, depression, dementia muscle weakness and muscular disuse atrophy. R20's Quarterly	F 282	R20's care plan is correctly implemented as of 09/03/2015. All residents care plan will be correctly implemented at Adams Health Care Center. Nursing staff education held on September 24, 2015 to review how to correctly implement a resident care plan. DON and/or her designee will conduct an audit one per week for 1 month, once per	9/24/15

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F 282	Continued From page 4 Minimum Data Set (MDS) an assessment tool dated 7/17/15 stated R20 had severe cognitive impairment. The MDS also indicated R20 was not steady when moving from seating to standing, and needed one person to physically assist with transfers and walking. R20's MDS stated during the last quarter she had more than 2 falls without injury and one fall with injury. Review of R20's electronic medical record revealed falls on 4/28/15, 5/11, 15, 17, & 27/2015, 6/10/15, 7/4/15, 8/9/15, 8/12/15, and 8/18/15 a total of 10 falls since 4/28/15. R20's Falls Care Plan, dated 7/21/15, stated R20 had a history of falls related to cognitive deficiencies and was unaware of her physical limitations and inability to safely transfer without a device. The Car plan continued that R20's gait was unsteady and she continued to self-transfer and did not use the call light or ask for assistance. An approach started 8/19/15, stated to observe frequently and place in supervised area when out of bed. R20's Mobility Care Plan, dated 7/21/15, indicated R20 was limited in mobility and ability to transfer related to bone/cartilage disorder and generalized weakness, unsteady gait, need for device and a history of falls. Approaches included do not leave resident in room alone when in wheelchair. On 9/2/15, at 7:09 a.m., R20 was propelling herself down the facility's West hallway. Nursing Assistant (NA)-C approached R20, talked to her about going to her room and pushed R20's wheelchair to her room in the North hallway. When arriving at R20's room, NA-C positioned R20's wheelchair facing a television set, locked R20's wheelchair and left. As soon as NA-C left	F 282	month for 3 months to monitor for compliance. Results will be forwarded to QA/QI Committee for further recommendations.	

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F 282	Continued From page 5	F 282		

the room, R20 stood up, turned, and attempted to push her locked wheelchair backwards. NA-E was informed of the situation and quickly intervened, assisting R20 to bed.

In an interview on 9/2/15, at 8:45 a.m., NA-C confirmed she took R20 to her room and left her sitting in her wheelchair. NA-C stated she was aware that R20 self-transfers, but denied knowing she was not to be left alone in her wheelchair in her room. NA-C stated that she learns about care plan updates in report at the start of each shift and staff can go online and look at each resident's care plans. When the care plan approach, "do not leave R20 alone in her room in her wheelchair" was shown to NA-C, she stated, "I'm sorry. I didn't know."

In an interview on 9/3/15, at 9:52 a.m., the Director of Nursing (DON) stated that care plan changes are communicated to staff on a 24-hour report sheet. The DON stated staff look at the 24-hour report sheet during report and can refer to it throughout their shift. The DON also stated there is a verbal report at the beginning of each shift, and staff listen to updates at that time.

In a review of the facility 24-hour report sheet no documentation was found referencing R20's 7/21/15 care plan change to not leave R20 alone in her room in her wheelchair.

A copy of the 24-hour report sheet with information on R20's 7/21/15 care plan change was requested but not received.

During an interview on 9/3/15, at 11:18 a.m., the DON confirmed she did not see any reference to the care plan change on the 24-hour report

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F 282	Continued From page 6 sheets.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and develop interventions to reduce the risk of pressure ulcer development for 1 of 3 residents (R57) reviewed for pressure ulcers and who had redness on their spine and sacrum. Findings include: R57's admission Minimum Data Set (MDS) an assessment tool dated 7/14/15, identified R57 had intact cognition, required limited assistance with transfers and bed mobility, and was at risk of pressure ulcer development but had no current pressure ulcers. R57's Pressure Ulcers Care Area Assessment dated 7/14/15, identified R57 had no current pressure ulcers or redness on his skin, but was at risk for pressure ulcer development related to his poor nutrition especially in the areas of "bony	F 314	R57 started a treatment of Skin Repair Cream to sacrum on 09/02/2015, and was offered a specialty mattress but refused until 09/21/2015. Resident is independent in all mobility around facility and does not have 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 healing 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 an audit once per week for one month and once per month for 3 months to monitor for compliance.	9/24/15

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F 314	Continued From page 7 prominences." R57's most recent Braden Scale For Predicting Pressure Sore (ulcer) Risk assessment dated 7/29/15, identified R57 to be "AT RISK" of pressure ulcer development, but did not identify R57 to have any current ulcers at the time. R57's progress notes dated 7/11/15, identified R57 "c/o [complained of] pain in coccyx and it was red...he [R57] wants an air bed...in other nursing home he had air bed and he did not break down." An additional note dated 7/20/15 and nine days late after 7/11/15 progress note, identified an, "Assessed sacral area ... has some blanchable redness ... has prominent bony prominences ... measures approximately 5 cm [centimeters] X [by] 5 cm." The progress note added, "Will call MD [medical doctor] for order for dressing to protect area from skin breakdown." However, the noted did not identify any immediate interventions to reduce R57's risk of pressure ulcer development. Furthermore, on 7/25/15 and 14 days after initial identification of the developed redness found in progress note dated 7/11/15, progress note identified, "...complained of stinging on lower back...noted a couple of red areas on lower spine about the size of nickels." No further progress notes identified any comprehensive assessment of R57's newly developed redness on his sacrum and spine, nor any interventions to be out in place to reduce the risk of worsening or new pressure ulcer development. During interview on 9/1/15, at 2:55 p.m. R57 stated he still had redness on his spine and sacrum as it was the "bony part" of his buttocks. R57 stated he develops redness on his sacrum and spine "from time to time", and was applying	F 314	Results will be forwarded to the QA/QI Committee for further recommendations.	

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some various creams from his bedside table to them when he noted them. Further more, R57 added he had requested to have an air mattress placed on his bed to reduce the redness and risk of pressure ulcer development, but was told "they [facility] didn't have one."

R57's care plan dated 7/20/15, identified R57 was "at risk for pressure ulcers related to poor nutrition and friction, and listed a goal for R57 of having his skin remain intact. The care plan did not identify R57 to have any current redness or pressure ulcers.

When interviewed on 9/1/15, at 3:19 p.m. nursing assistant (NA)-G stated R57 was "pretty much independent" with his cares, and had no current pressure ulcers that she was aware of.

During interview on 9/2/15, at 8:18 a.m. registered nurse (RN)-A stated R57 had no current pressure ulcers, but did develop redness on his buttocks and spine "at times." Further, R57 would request creams be applied to these developed red areas at times, and staff encouraged him to reposition frequently.

When interviewed on 9/2/15, at 8:26 a.m. the director of nursing (DON) stated she was unaware of any developed redness on R57's sacrum or spine, and stated, "[I] haven't had anything reported to me." The DON was unaware R57 had requested an air bed to prevent skin breakdown and when sharing this with the DON she said, "That's the first I've heard of it."

During observation and subsequent interview on 9/2/15, at 8:45 a.m. the DON and the surveyor viewed R57's sacrum and spine. R57 had an

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F 314	Continued From page 9 area of redness on his sacrum that was approximately 4 inches in size, with a center of non-blanchable redness which the DON measured at "three by two and a half [centimeters]", along with some red areas on his vertebrae (spine) which were blanchable when pushed on. The DON stated R57 should have an air bed in place to reduce his risk of pressure ulcer development as he "definitely has potential to breakdown." Further, The DON stated R57 had not been comprehensively re-assessed for pressure ulcer risk since the most recent Braden Scale (7/29/15) as she was not aware R57 was developing these areas of redness on his sacrum and spine. On 9/3/15, at 9:04 a.m. the DON stated she had consulted with a wound nurse, and had been told R57 should have a daily application of skin repair cream. Furthermore, the DON stated she reviewed R57's medical record and R57 had not been re-assessed for pressure ulcer development since developing the redness on his sacrum and spine, "I do not see it", but added, R57 should have been re-assessed. An undated facility Policy and Procedure for the Prevention and Treatment of Skin Breakdown read, "It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity .. [and] to implement preventative measures..." Further, the policy directed staff to complete a "Comprehensive Evaluation of Skin Risk Factors" for a newly developed pressure ulcer.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive	F 315		9/24/15

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F 315	Continued From page 10 assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess 1 of 3 residents (R3) reviewed for urinary incontinence and had a change in continence function. Findings include: R3's admission Minimum Data Set (MDS) dated 4/15/15, indicated R3 had moderate cognitive impairment, was always continent of urine and had no urinary toileting program. A review of R3's Quarterly MDS dated 7/16/15, indicated the resident had moderately impaired cognitive impairment, was occasionally incontinent of urine and had no urinary toileting program. R3's current care plan dated 8/6/15, identified R3 as being continent of bladder. The target goal for R3 is to remain continent of bladder through the next review. Interventions that were put in place were to have episodes of incontinence reported to the nurse and chart in the point of care a computerized charting program. R3's most recent Bladder Assessment, dated	F 315	R3 72 hour bowel and bladder assessment initiated on 09/03/2015 and revealed that he is continent of bowel and occasional incontinent of urine. All residents of Adams Health Care Center will be assessed for newly identified incontinence and necessary changes will be implemented to reflect current status. nursing staff in-serviced on 09/24/2015 to review facility policy and procedure for newly identified incontinence and for implementation of necessary changes to reflect current status. DON and/or her designee will conduct an audit once per week for one month and once per month for 3 months to monitor for compliance. Results will be forwarded to QA/QI Committee for further recommendations.	

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6/18/15, indicated that R3 was continent of bladder.

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.

When interviewed on 9/2/15, at 9:32 a.m., Nursing Assistant (NA)-E stated that he sometimes has to change R3's bedding due to incontinence.

When interviewed on 9/2/15, at 1:47 p.m., R3 stated that she soils her underwear with urine at least half the time prior to going to the toilet. She stated that she had told the nurse in the past whenever her bedding was soiled and needed to be changed. R3 stated that her urinary incontinence happened mostly at night but occasionally during the day.

When interviewed on 9/3/15, at 9:49 a.m., licensed practical nurse (LPN)- B, stated that the nursing assistants are supposed to report to the nursing staff any instances of incontinence. She stated that she is not aware of ever being told of R3's urinary incontinence episodes.

When interviewed on 9/3/15, at 11:13 a.m., R3 stated that she did have an episode of urinary incontinence this morning. However, this was not reported to the licensed nurse by NA's.

When interviewed on 9/3/15, at 1:23 p.m., the Director of Nursing (DON) stated that she was not aware that the resident had episodes of

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F 315	Continued From page 12 urinary incontinence. She stated that if the resident had episodes of urinary incontinence that is something that staff should report right away. She stated that the nursing assistants should have notified the nursing staff. She stated that she would have expected a bladder assessment to have been done if the resident had an episode of urinary incontinence. When interviewed on 9/3/15, at 1:51 p.m., NA-F stated that if a resident had an episode of urinary incontinence she would first document it in the computerized chart and then let the nurse know. She stated that she did notice at least one time where R3 did have an episode of urinary incontinence where the resident had soiled pants that needed to be changed but no could not remember the date. After review of the facility policy titled, Bladder and Bowel Assessment Policy and Procedure dated 9/22/15, it stated that it is the policy of Adams Health Care Center that the facility will ensure that each resident that is incontinent of bladder and /or bowel is identified and assessed, given the opportunity to achieve continence or restore as much normal bladder and/or bowel function as possible. A Bladder and Bowel Assessment will be completed annually or if a significant change in continent status is identified.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		9/24/15

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F 323	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to assess resident safety while smoking for 1 of 1 resident (R62) reviewed for smoking; failed to implement care planned fall interventions for 1 of 1 resident (R20) identified with chronic falls history; failed to securely attach grab bar for safe use for 1 of 1 resident (R32) with a grab rail attached to bed and used for repositioning and getting in and out of bed; failed to prevent misuse of a wheeled walker according to manufacturers recommendations which put 1 of 1 resident (R3) at moderate risk of falling and sustaining an injury. Findings include: LACK OF SMOKING ASSESSMENT FOR SAFETY: R62 was admitted to the facility on 7/28/15 with diagnoses to include: acute respiratory failure, obstructive chronic airway, difficulty in walking, muscle weakness, memory loss, and tobacco use disorder. R62 had a guardian appointed to her through Mower County. 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	F 323	R3 has been educated on safe use of her wheeled walker per manufacturer recommendations, R20's care plan for fall intervention is implemented, R32'grab bar is securely attached to his bed and R62 has been assessed for smoking safety. All residents of Adams Health Care Center are receiving adequate supervision and assistance devices to prevent accidents. Nursing staff in-serviced on 09/24/2015 to review facility policy for assessment of resident smoking, on using mobility device per manufacturer recommendation, on how to correctly implement a resident's plan of care and on how to secure a grab bar safely. DON and/or her designee will conduct an audit once per week for one month and once per month for 3 months to monitor for compliance. Results will be forwarded to QA/QI Committee for further recommendations.	

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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."

Review of R62's progress notes revealed notations of R62 observed smoking on: 8/3/15, 8/6/15, 8/9/15, 8/17/15, and 8/30/15.

On 09/01/15 at 3:49 p.m. social services (SS)-A was interviewed regarding R62 smoking. "She is not supposed to be smoking at all because she is wearing a nicotine patch [a physician ordered medication]. With her memory she doesn't remember what we have talked about. The director of nursing (DON) has tried to explain that to her. If we catch her smoking we redirect her into the facility and don't let her finish her cigarette." SS-A was asked if R62 was assessed to safely smoke, "No, because we are a smoke free facility. They [residents] are just supposed to be smoke free."

On 09/03/15 at 9:00 a.m. the DON and administrator were interviewed regarding R62 receiving a smoking assessment, "No we did not because we are a smoke free facility. She [R62] has been educated numerous times not smoke. She does still smoke." The DON and adminstrator were asked if R62 is safe to

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F 323	Continued From page 15 independently smoke, "I have never seen her outside smoking so I can't answer that question. She has a patch [Nicotine prescription medication]. We educate her when we know she has been smoking. There was no smoking assessment completed." Adams Health Care Center Smoking Policy dated 5/24/10 read, "III. Procedure; A. Adams Health Care Center is a smoke-free facility. No smoking or use of smoking materials will be allowed in the building... B. No smoking or use of smoking materials will be allowed on the Adams Health Care Center's grounds, including parking lots, except at the following locations. Employees: Gazebo area on north side of building Residents: No smoking allowed on grounds or premises. Resident's will be informed on admission by social services." LACK OF FOLLOWING PLAN OF CARE INTERVENTIONS IN REGARDS TO PREVENTION OF FALLS: R20's Admission Record identified R20 had diagnoses that included Alzheimer's disease, depression, dementia muscle weakness and muscular disuse atrophy. R20's Quarterly Minimum Data Set (MDS) dated 7/17/15 stated R20 had severe cognitive impairment. The MDS also indicated R20 was not steady when moving from seating to standing, and needed one person to physically assist with transfers and walking. R20's MDS stated during the last quarter she had more than 2 falls without injury and one fall with injury. Review of R20's electronic medical record revealed 10 falls from April 28, 2015 to August 18, 2015. On 9/2/15, at 7:09 a.m., R20 was propelling	F 323		

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herself down the facility's West hallway. Nursing Assistant (NA)-C approached R20, talked to her about going to her room and pushed R20's wheelchair to her room in the North hallway. When arriving at R20's room, NA-C positioned R20's wheelchair facing a television set, locked R20's wheelchair and left. As soon as NA-C left the room, R20 stood up, turned, and attempted to push her locked wheelchair backwards. NA-E was informed of the situation and quickly intervened, assisting R20 to bed.

R20's Falls Care Plan, dated 7/21/15, stated R20 had a history of falls related to cognitive deficiencies and was unaware of her physical limitations and inability to safely transfer without a device. The care plan continued that R20's gait was unsteady and she continued to self-transfer and did not use the call light or ask for assistance. An approach started 8/19/15, stated to observe frequently and place in supervised area when out of bed.

R20's Mobility Care Plan, dated 7/21/15, indicated R20 was limited in mobility and ability to transfer related to bone/cartilage disorder and generalized weakness, unsteady gait, need for device and a history of falls. Approaches included do not leave resident in room alone when in wheelchair.

In an interview on 9/2/15, at 8:45 a.m., NA-C confirmed she took R20 to her room and left her sitting in her wheelchair. NA-C stated she was aware that R20 self-transfers, but denied knowing she was not to be left alone in her wheelchair in her room. NA-C stated that she learns about care plan updates in report at the start of each shift and staff can go online and look at each resident's care plans. When the care plan

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approach, "do not leave R20 alone in her room in her wheelchair" was shown to NA-C, she stated, "I'm sorry. I didn't know."

In an interview on 9/3/15, at 9:52 a.m., the Director of Nursing (DON) stated that care plan changes are communicated to staff on a 24-hour report sheet. The DON stated staff look at the 24-hour report sheet during report and can refer to it throughout their shift. The DON also stated there is a verbal report at the beginning of each shift, and staff listen to updates at that time.

In a review of the facility 24-hour report sheet no documentation was found referencing R20's 7/21/15 care plan change to not leave R20 alone in her room in her wheelchair.

A copy of the 24-hour report sheet with information on R20's 7/21/15 care plan change was requested but not received.

In an interview on 9/3/15, at 11:18 a.m., the DON confirmed she did not see any reference to the care plan change in the 24-hour report sheets.

LACK OF SECURED GRAB BARS FOR RESIDENT SAFETY WITH USE:

R32's Admission Record indicated diagnoses including dementia, osteoporosis, and pain. R32's Annual Minimum Data Set (MDS), dated 7/10/15, indicated R32 had severely impaired cognition, required extensive assistance for bed mobility and transfers and was unsteady when moving from sitting to standing. R32's Mobility Care Plan indicated impaired mobility related to generalized weakness, history of left hip fracture and rib fractures requiring assistance with bed

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mobility, transfers and wheelchair locomotion. An approach dated 7/22/15, directs staff to provide physical assist of 1-2 staff with bed mobility and transfers; R32's compliance varies as and staff are to use an EZ stand for transfers

On 8/31/15, at 5:42 p.m., the right hand grab bar on R32's bed found to be easily moved from side to side and securely attached to bed frame.

In an interview on 9/2/15, at 7:41 a.m., Nursing Assistant (NA)-A stated she would tell the maintenance man if she found a loose grab bar. NA-A stated she routinely takes care of R32.

In an interview on 9/2/15, at 8:02 a.m., Maintenance Director (MD)-A stated staff put work for him on a clip board that is kept at the nurse's station. MD-A stated he checks the clip board daily and he has not received any requests to fix grab bars. MD-A was asked to check R32's grab bar and when finding it loose, MD-A stated, "I guess I need to tighten that up."

In an interview on 9/2/15, at 8:14 a.m., NA-B stated that R32 uses the grab bar to sit up.

In a follow-up interview on 9/2/15, at 8:22 a.m., NA-A stated that R32 occasionally uses the grab bar to sit at the side of the bed, as part of transferring out of bed.

A grab bar policy was requested and received; the policy does not address maintenance or routine checking of grab bars.
MOBILITY DEVICE USED INCORRECTLY:

R3's quarterly Minimum Data Set (MDS) dated 7/16/15, identified R3 had moderate cognitive

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impairment, and used a walker for mobility.

During observation on 8/31/15, at 2:34 p.m. R3 was seated on a Nova brand four wheeled walker in the hallway of the North Unit. R3 wheeled around the hallway while seated on the device while her arms were crossed with her elbows resting on the handles of the device. R3 was not holding onto the device for security when in motion. When observed on 9/1/15, at 9:27 a.m. R3 was again seated on the seat portion of her four wheeled walker in the doorway of the beauty shop conversing with other residents. R3 proceeded to wheel herself down the hallway towards the dining room while seated on the four wheeled walker. R3 again had her arms crossed and was not holding onto the walker for security.

When interviewed on 9/2/15, at 12:59 p.m. licensed practical nurse (LPN)-D stated R3 sits on her four wheeled walker and pushes herself around "quite often." The staff had tried to educate her on safe use of walker, despite her moderate cognitive impairment, on not doing so, but it hadn't help and R3 continued to do it. LPN-D stated she was unaware of what the four wheeled walkers manufacturer advised regarding this practice, but added she felt it was unsafe to do because "She [R3] can easily fall" off the walker while it is in motion. Further, LPN-D observed R3's four wheeled walker and stated it had a label fixed to the leg which read, "DO NOT use as a wheelchair or to transport someone...lock hand brakes when sitting or while seated."

During interview on 9/2/15, at 1:15 p.m. the director of nursing (DON) stated staff should be reminding R3 that it is unsafe to move herself

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F 323	Continued From page 20 around while seated on the walker "because its dangerous." Furthermore, the DON added, therapy should of been contacted and an evaluation would have been completed for R3's mobility. An undated Nova Rolling Walker User Guide read, "Safety Warning Instructions" which included, "DO NOT use as a wheelchair or to transport someone", and, "DO NOT self propel or scoot around while seated."	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		9/24/15

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F 329	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to monitor for significant adverse consequences of smoking cigarettes while wearing a nicotine patch for 1 of 1 resident (R62) who was on a smoking cessation program which included a nicotine patch and chose to smoke even though the nicotine patch had a warning in regards to smoking while wearing the patch and failed to follow up on recommendations from a psychiatric evaluation timely for 1 of 2 residents (R12) reviewed for unnecessary medications. Findings include: LACK OF ASSESSMENT TO DETERMINE IF ADVERSE AFFECTS WERE IMMANENT FOR USE OF NICOTINE PATCH AND SMOKING AT THE SAME TIME: R62 was admitted to the facility on 7/28/15 with diagnoses to include: acute respiratory failure, obstructive chronic airway, difficulty in walking, muscle weakness, memory loss, and tobacco use disorder. R62 had a guardian appointed to her through Mower County. 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. Review of R62's Medication Administration Record (MAR) revealed an order for "nicotine patch; 21 mcg/24, apply patch transdermally one	F 329	R12's physician recommendations are now followed per doctor's order. R62's nicotine patch has been discontinued per doctor's order as she continues to smoke. All residents of Adams Health Care Center will be assessed and monitored for any significant adverse consequences of combined substances and medications and will receive all medical provider's recommendations for medications in a timely manner. Nursing staff in-serviced on 09/24/2015 regarding the implementation of medical provider recommendations for significant adverse consequences with respect to psychotropic medications, and the monitoring for significant adverse consequences of smoking while wearing a nicotine patch. DON and/or designee will conduct an audit once per week for one month and once per month for 3 months to monitor for compliance. Results will be forwarded to QA/QI Committee for further recommendations.	

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time a day. Remove old patch before placing new patch on." R62's MAR indicated R62 was administered the nicotine patch daily 8/1/15 through 9/2/15.

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.

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."

Review of R62's progress notes revealed notations of R62 observed smoking on: 8/3/15, 8/6/15, 8/9/15, 8/17/15, and 8/30/15. Furthermore, there was no information documented nor provided in regards to the nicotine patch having been removed, nor if the physician had been informed of the resident smoking while wearing the nicotine patch.

On 09/01/15 at 3:49 p.m. social services (SS)-A was interviewed regarding R62 smoking and said, "She [R62] is not supposed to be smoking at all because she is wearing a nicotine patch. With her memory she doesn't remember what we have talked about. The director of nursing has tried to explain that to her. If we catch her smoking we redirect her into the facility and don't let her finish her cigarette."

On 9/3/15 at 9:00 a.m. the director of nursing (DON) stated R62 wore a nicotine patch but did

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F 329	Continued From page 23 not know if the nicotine patch was removed when R62 was known to have been smoking. Nicotine patch warnings from the Food and Drug Administration, dated 1/2010 read, "Do not use if you continue to smoke, chew tobacco, use snuff, use nicotine gum, or use another patch or other nicotine containing products...When using this product do not smoke even when not wearing the patch. The nicotine in your skin will still be entering the bloodstream for several hours after you take off the patch." Nicotine patch directions include"...stop smoking completely when you being using the patch." LACK OF TIMELY MEDICATION ADJUSTMENT FOLLOWING PSYCHIATRIC RECOMMENDATIONS: R12 had been admitted according to the current physician orders R12 was admitted to the facility with diagnosis including anxiety and insomnia. The physician orders also identified R12 as receiving the medications clonazepam (antianxiety medication) and Trazodone (antidepressant medication used for insomnia). A psychiatric evaluation was ordered by the physician due to increased anxiety and behaviors and an evaluation was attempted on 5/28/15. There was no evaluation found in the record and upon asking for it's location it was faxed from the psychiatrist to the facility on 9/3/15. Review of the referral form from the appointment read, "attempted neurocognitive testing, although R12 was not able to focus well at all. Will attempt further testing if he is more alert." A new diagnosis of cognitive disorder was identified.	F 329		

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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 medication] would be an ideal medication to be used, starting the doses of 7.5 mg, increasing it to potentially 15 to 30 mg as needed to help with sleep as well as with anxiety. I understand that a number of problematic behaviors have being noticed at night and based on current evidence, the current dose of clonazepam is not being helpful, hence this should be an appropriate consideration." "From an anxiety/cognitive risk assessment perspective, i would recommend a gradually tapering the clonazepam from the current total 4 mg a day over a period of the next 4 weeks completely and stopped. In its place if anxiety remains an issue and symptomatic treatment is necessary, then small doses of quetiapine [antipsychotic medication] at 12.5 to 25 mg could be utilized." During an interview on 09/03/2015, at 10:11 a.m. licensed practical nurse (LPN)-A verified the recommendations from the psych eval had not been followed. She stated that the psych referral was not scanned in to the facility and should have been. LPN-A stated if the nurse didn't get the referral back she should have called to get it. She stated apparently no one called about it so it didn't get addressed. She stated, this (the final report) was at the clinic and she had just requested it be faxed to them, the facility did not	F 329		

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	245509	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS HEALTH CARE CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 25 have it to determine what changes to R12 medication regimen needed changing. A policy regarding consult was requested and none provided.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the consulting pharmacist failed to identify missing follow up recommendations from a psychiatric evaluation for 1 of 2 R12 reviewed for unnecessary medications. Findings include: R12 had been admitted according to the current physician orders R12 was admitted to the facility with diagnosis including anxiety and insomnia. The physician orders also identified R12 as receiving the medications clonazepam (antianxiety medication) and Trazodone (antidepressant medication used for insomnia).	F 428	The consulting pharmacist will identify missing follow-up recommendations from any psychiatric evaluation in a timely manner. All physician's recommendations regarding psychotropic medications will be identified and followed-up in a timely manner for all residents of Adams Health Care Center. The pharmacy consultant in-serviced on 09/18/2015 regarding the implementation of medical provider recommendations with respect to psychotropic medications. DON will conduct an audit once per month for 3 months to monitor for compliance. Results will be forwarded to QA/QI	9/18/15

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F 428	Continued From page 26 A psychiatric evaluation was ordered by the physician due to increased anxiety and behaviors and an evaluation was attempted on 5/28/15. There was no evaluation found in the record and upon asking for it's location it was faxed from the psychiatrist to the facility on 9/3/15. Review of the referral form from the appointment read, "attempted neurocognitive testing, although R12 was not able to focus well at all. Will attempt further testing if he is more alert." A new diagnosis of cognitive disorder was identified. 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 medication] would be an ideal medication to be used, starting the doses of 7.5 mg, increasing it to potentially 15 to 30 mg as needed to help with sleep as well as with anxiety. I understand that a number of problematic behaviors have being noticed at night and based on current evidence, the current dose of clonazepam is not being helpful, hence this should be an appropriate consideration." "From an anxiety/cognitive risk assessment perspective, i would recommend a gradually tapering the clonazepam from the current total 4 mg a day over a period of the next 4 weeks completely and stopped. In its place if anxiety remains an issue and symptomatic treatment is necessary, then small doses of quetiapine [antipsychotic medication] at 12.5 to 25 mg could be utilized."	F 428	Committee for further recommendations.	

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F 428	Continued From page 27 During an interview on 09/03/2015, at 10:11 a.m. licensed practical nurse (LPN)-A verified the recommendations from the psych eval had not been followed. She stated that the psych referral was not scanned in to the facility and should have been. LPN-A stated if the nurse didn't get the referral back she should have called to get it. She stated apparently no one called about it so it didn't get addressed. She stated, this (the final report) was at the clinic and she had just requested it be faxed to them, the facility did not have it to determine what changes to R12 medication regimen needed changing. A policy regarding consult was requested and none provided.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431		9/24/15

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F 431	Continued From page 28 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure expired tuberculin testing medication had been removed before an outdated dose was administered to 1 of 1 resident (R66) newly admitted to facility. Findings include: Upon review of the facility's only medication storage room on 09/01/2015 at 1:44 p.m. an expired vial of Aplisol PPD [purified protein derivative; used in administration of tuberculin skin testing] solution was located and available for use in the medication refrigerator. The vial had an open date of 7/30/15 and discard date of 9/30/15 however, the expiration date was calculated in error as the solution is affective for up to 30 days after opening and NOT 60 days. Approximately 1/4 of the Aplisol solution remained.	F 431	All expired medications are discarded upon date of expiration and outdated doses will not be administered to any residents of Adams Health Care Center. Nursing staff in-serviced on 09/24/2015 regarding removal of expired medication and ensuring that outdated doses will not be administered to any residents. DON and/or designee will conduct an audit once per week for one month and once per month for 3 months to monitor for compliance. Results will be forwarded to QA/QI Committee for further recommendations.	

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F 431	Continued From page 29 On 9/1/15 at 1:50 p.m. the director of nursing (DON) was asked how long a vial of PPD solution was to remain in use after opening and she said, "I think it is 60 days, that is what the pharmacist told me." Minutes later the DON added, "That's my fault I just called the pharmacist and it is 30 days." The DON verified that one resident, R66, received a dose from the expired Aplisol vial. The DON then removed the Aplisol vial from stock supply. R66 was admitted to the facility on 8/31/15. R66's Medication Administration Record (MAR) revealed R66 received the first step PPD on 8/31/15. Facility document, Medications With Shortened Expiration Dates, undated, indicated "Aplisol, Tuberculin PPD, diluted, injection;...vials in use more than 30 days should be discarded due to possible oxidation and degradation which may effect potency." An Aplisol package insert read, "...Vials in use for more than 30 days should be discarded."	F 431		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation & interview, the facility failed to ensure the exhaust vents were cleaned	F 465	All exhaust vents were cleaned to maintain a sanitary bathroom environment	9/24/15

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F 465	Continued From page 30 to maintain a sanitary bathroom environment in 17 out of 23 bathrooms (101, 102, 103, 105, 106, 107, 108, 109, 112, 114, 124, 125, 126, 128, 129, 131, and 135) used by residents who reside in bedrooms adjoining these bathrooms. 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	F 465	and will be cleaned on an going basis. The Maintenance staff was in-serviced to review all bathrooms vents cleaning schedule. The Environmental Services Director will conduct an audit weekly then monthly thereafter to monitor for compliance. Results will be forwarded to the QA/QI Committee for further recommendations.	

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F 465	Continued From page 31 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 fixtures (bathroom)..." Policy and Procedure for Cleaning Vents, dated 1/15/15 read, "Each Monday housekeeping will take a duster and clean all bathroom vents in Adams Health Care Center. Staff will check off when done. Bi-Annually vents will be taken down by maintenance department and cleaned out good and repainted as needed. Duct work will be vacuumed out at this time."	F 465		

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	245509	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/02/2015**

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ADAMS HEALTH CARE CENTER	**810 WEST MAIN STREET** **ADAMS, MN 55909**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, 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 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 St Paul, MN 55101-5145, or	K 000	EPOC	

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.

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K 000	Continued From page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Adams Health Care Center is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1976 and determined to be of Type II(111) construction. In 1992, an addition was constructed and determined to be of Type II (111) construction.. 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 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE	K 000		

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K 000	Continued From page 2 FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The facility is fully sprinklered. The facility has a fire alarm system with partial smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 49 beds and had a census of 42 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Chapters 19.3.4.1, 9.6.1.4, 1999 NFPA 72, Section 7-3.2. The deficient practice	K 054	The smoke detector sensitivity testing is scheduled to be completed on 10/05/2015 by Simplex Grimell and will be documented. The annual fire alarm report now contain	10/5/15

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K 054	Continued From page 3 could affect all 42 residents. Findings include: On facility tour between 9:30 AM and 12:30 PM on 09/02/2015, the review of the annual fire alarm inspection and testing report from Schmitz Electric, dated 04/23/2015, indicated that the 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.	K 054	all the required information per NFPA 72. The Maintenance Director in-serviced regarding maintenance of fire system in accordance with the requirements of 2000 NFPA 101 and regarding the fire alarm report. The Maintenance Director is responsible to monitor for compliance.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to run the emergency generator in accordance with the requirements of	K 144	The emergency generator will be run monthly and documented in the monthly generator log each time it is completed.	9/24/15

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K 144	Continued From page 4 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6.4.2. The deficient practice could affect all 42 residents. Findings include: On facility tour between 9:30 AM and 12:30 PM on 09/02/2015, documentation review of the monthly generator logs revealed there was no documentation for the monthly run for December 2014 through August 2015. This deficient practice was confirmed by the Facility Maintenance Director (JK) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc. No documentation for monthly emergency generator run for December 2014 and January through August 2015.	K 144	The Maintenance Director was in-serviced on 09/24/2015 regarding generator weekly inspection and exercise under load for 30 minutes per month. The maintenance Director is responsible to monitor for compliance.	

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MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota 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

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

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00754	A. BUILDING: _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS HEALTH CARE CENTER	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000	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	

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On August 31, September 1, 2, & 3, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000	Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and	2 302		9/24/15

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2 302	Continued From page 2 related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to ensure consumers were provided information regarding Alzheimer's disease and dementia training, including a description of the training program, the categories of employees trained, the frequency of training and the basic topics covered in the training in a written or electronic form. This had the potential to affect all 41 residents and their families. Findings include: During a review of the facility's Alzheimer's training program, there was no information or documentation that indicated that the consumers (resident families) were provided a description of Alzheimer's training program, categories of employees trained, frequency of training and the basic topics covered. During an interview on 9/3/15, at 1:37 p.m. licensed social worker (LSW)-A stated no information on the facility dementia training is	2 302	Completed on 09/24/2015	

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2 302	Continued From page 3 provided to residents nor their families to her knowledge. When interviewed on 9/3/15, at 1:50 p.m. the administrator stated the facility used to have a booklet available to the residents and public with information about dementia and the facility training, but it had gone missing. She then said, "[I] don't know where that book went." Furthermore, no information on the training was included in the admission packets provided to families when a resident had been admitted to the facility. SUGGESTED METHOD OF CORRECTION: The DON or designee could add information regarding staff training to the resident admission packet so consumers were aware of this information. The DON or designee could educate staff about this requirement and conduct audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 435	MN Rule 4658.0210 Subp. 2 A.B. Room Assignments Room assignment complaints. A nursing home must develop and implement written policies and procedures for addressing resident complaints, including complaints regarding room assignments and roommates. At a minimum, the policies and procedures must include the following: A. a mechanism for informal dispute resolution of room assignment and roommate complaints; and B. a procedure for documenting the complaint and its resolution.	2 435		9/24/15

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2 435	Continued From page 4 This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to provide adequate notice of a new roommate for 1 of 2 residents (R30) reviewed for admission, transfer, and discharge. 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. When interviewed on 9/1/15, at 2:46 p.m. licensed social worker (LSW)-A stated R30 had a recent change in roommate, but she was unable to locate any documentation R30 had been notified he was receiving a new roommate prior to the new resident's admission. A facility Room & Roommate Changes policy dated 8/2014, identified a procedure which included, "... All residents will be given notice when they will be receiving a new roommate..." and added, "...All residents will be given notice when a change in roommate is to occur. Adams Health Care Center will explain why the change in roommate is necessary..." SUGGESTED METHOD OF CORRECTION: The administrator or designee could review policies and procedures for room changes, and in-service staff regarding providing advanced notice of a	2 435	Completed on 09'24/2015	

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2 435	Continued From page 5 change in roommate or room; then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 435		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: The facility failed to ensure care planned interventions for fall prevention were followed for 1 of 5 residents (R20) reviewed for accidents. Findings include: R20's Admission Record identified R20 had diagnoses that included Alzheimer's disease, depression, dementia muscle weakness and muscular disuse atrophy. R20's Quarterly Minimum Data Set (MDS) an assessment tool dated 7/17/15 stated R20 had severe cognitive impairment. The MDS also indicated R20 was not steady when moving from seating to standing, and needed one person to physically assist with transfers and walking. R20's MDS stated during the last quarter she had more than 2 falls without injury and one fall with injury. Review of R20's electronic medical record revealed falls on 4/28/15, 5/11, 15, 17, & 27/2015, 6/10/15, 7/4/15, 8/9/15, 8/12/15, and 8/18/15 a total of 10 falls	2 565	Completed on 09/24/2015	9/24/15

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2 565	Continued From page 6 since 4/28/15. R20's Falls Care Plan, dated 7/21/15, stated R20 had a history of falls related to cognitive deficiencies and was unaware of her physical limitations and inability to safely transfer without a device. The Car plan continued that R20's gait was unsteady and she continued to self-transfer and did not use the call light or ask for assistance. An approach started 8/19/15, stated to observe frequently and place in supervised area when out of bed. R20's Mobility Care Plan, dated 7/21/15, indicated R20 was limited in mobility and ability to transfer related to bone/cartilage disorder and generalized weakness, unsteady gait, need for device and a history of falls. Approaches included do not leave resident in room alone when in wheelchair. On 9/2/15, at 7:09 a.m., R20 was propelling herself down the facility's West hallway. Nursing Assistant (NA)-C approached R20, talked to her about going to her room and pushed R20's wheelchair to her room in the North hallway. When arriving at R20's room, NA-C positioned R20's wheelchair facing a television set, locked R20's wheelchair and left. As soon as NA-C left the room, R20 stood up, turned, and attempted to push her locked wheelchair backwards. NA-E was informed of the situation and quickly intervened, assisting R20 to bed. In an interview on 9/2/15, at 8:45 a.m., NA-C confirmed she took R20 to her room and left her sitting in her wheelchair. NA-C stated she was aware that R20 self-transfers, but denied knowing she was not to be left alone in her wheelchair in her room. NA-C stated that she learns about care plan updates in report at the start of each	2 565		

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2 565	Continued From page 7 shift and staff can go online and look at each resident's care plans. When the care plan approach, "do not leave R20 alone in her room in her wheelchair" was shown to NA-C, she stated, "I'm sorry. I didn't know." In an interview on 9/3/15, at 9:52 a.m., the Director of Nursing (DON) stated that care plan changes are communicated to staff on a 24-hour report sheet. The DON stated staff look at the 24-hour report sheet during report and can refer to it throughout their shift. The DON also stated there is a verbal report at the beginning of each shift, and staff listen to updates at that time. In a review of the facility 24-hour report sheet no documentation was found referencing R20's 7/21/15 care plan change to not leave R20 alone in her room in her wheelchair. A copy of the 24-hour report sheet with information on R20's 7/21/15 care plan change was requested but not received. During an interview on 9/3/15, at 11:18 a.m., the DON confirmed she did not see any reference to the care plan change on the 24-hour report sheets. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could in-service staff regarding how to correctly implement a resident plan of care, and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		

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2 830	Continued From page 8	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to assess resident safety while smoking for 1 of 1 resident (R62) reviewed for smoking; failed to implement care planned fall interventions for 1 of 1 resident (R20) identified with chronic falls history; failed to securely attach grab bar for safe use for 1 of 1 resident (R32) with a grab rail attached to bed and used for repositioning and getting in and out of bed; failed to prevent misuse of a wheeled walker according to manufacturers recommendations which put 1 of 1 resident (R3) at moderate risk of falling and sustaining an injury. Findings include: LACK OF SMOKING ASSESSMENT FOR SAFETY: R62 was admitted to the facility on 7/28/15 with	2 830	Completed on 09/24/2015	9/24/15

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2 830	Continued From page 9 diagnoses to include: acute respiratory failure, obstructive chronic airway, difficulty in walking, muscle weakness, memory loss, and tobacco use disorder. R62 had a guardian appointed to her through Mower County. 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." Review of R62's progress notes revealed notations of R62 observed smoking on: 8/3/15, 8/6/15, 8/9/15, 8/17/15, and 8/30/15. On 09/01/15 at 3:49 p.m. social services (SS)-A was interviewed regarding R62 smoking. "She is not supposed to be smoking at all because she is wearing a nicotine patch [a physician ordered medication]. With her memory she doesn't remember what we have talked about. The director of nursing (DON) has tried to explain that to her. If we catch her smoking we redirect her into the facility and don't let her finish her	2 830		

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2 830	Continued From page 10 cigarette." SS-A was asked if R62 was assessed to safely smoke, "No, because we are a smoke free facility. They [residents] are just supposed to be smoke free." On 09/03/15 at 9:00 a.m. the DON and administrator were interviewed regarding R62 receiving a smoking assessment, "No we did not because we are a smoke free facility. She [R62] has been educated numerous times not smoke. She does still smoke." The DON and adminstrator were asked if R62 is safe to independently smoke, "I have never seen her outside smoking so I can't answer that question. She has a patch [Nicotine prescription medication]. We educate her when we know she has been smoking. There was no smoking assessment completed." Adams Health Care Center Smoking Policy dated 5/24/10 read, "III. Procedure; A. Adams Health Care Center is a smoke-free facility. No smoking or use of smoking materials will be allowed in the building... B. No smoking or use of smoking materials will be allowed on the Adams Health Care Center's grounds, including parking lots, except at the following locations. Employees: Gazebo area on north side of building Residents: No smoking allowed on grounds or premises. Resident's will be informed on admission by social services." LACK OF FOLLOWING PLAN OF CARE INTERVENTIONS IN REGARDS TO PREVENTION OF FALLS: R20's Admission Record identified R20 had diagnoses that included Alzheimer's disease, depression, dementia muscle weakness and muscular disuse atrophy. R20's Quarterly	2 830		

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2 830	Continued From page 11	2 830		

Minimum Data Set (MDS) dated 7/17/15 stated R20 had severe cognitive impairment. The MDS also indicated R20 was not steady when moving from seating to standing, and needed one person to physically assist with transfers and walking. R20's MDS stated during the last quarter she had more than 2 falls without injury and one fall with injury. Review of R20's electronic medical record revealed 10 falls from April 28, 2015 to August 18, 2015.

On 9/2/15, at 7:09 a.m., R20 was propelling herself down the facility's West hallway. Nursing Assistant (NA)-C approached R20, talked to her about going to her room and pushed R20's wheelchair to her room in the North hallway. When arriving at R20's room, NA-C positioned R20's wheelchair facing a television set, locked R20's wheelchair and left. As soon as NA-C left the room, R20 stood up, turned, and attempted to push her locked wheelchair backwards. NA-E was informed of the situation and quickly intervened, assisting R20 to bed.

R20's Falls Care Plan, dated 7/21/15, stated R20 had a history of falls related to cognitive deficiencies and was unaware of her physical limitations and inability to safely transfer without a device. The care plan continued that R20's gait was unsteady and she continued to self-transfer and did not use the call light or ask for assistance. An approach started 8/19/15, stated to observe frequently and place in supervised area when out of bed.

R20's Mobility Care Plan, dated 7/21/15, indicated R20 was limited in mobility and ability to transfer related to bone/cartilage disorder and generalized weakness, unsteady gait, need for device and a history of falls. Approaches included do not leave

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2 830	Continued From page 12 resident in room alone when in wheelchair. In an interview on 9/2/15, at 8:45 a.m., NA-C confirmed she took R20 to her room and left her sitting in her wheelchair. NA-C stated she was aware that R20 self-transfers, but denied knowing she was not to be left alone in her wheelchair in her room. NA-C stated that she learns about care plan updates in report at the start of each shift and staff can go online and look at each resident's care plans. When the care plan approach, "do not leave R20 alone in her room in her wheelchair" was shown to NA-C, she stated, "I'm sorry. I didn't know." In an interview on 9/3/15, at 9:52 a.m., the Director of Nursing (DON) stated that care plan changes are communicated to staff on a 24-hour report sheet. The DON stated staff look at the 24-hour report sheet during report and can refer to it throughout their shift. The DON also stated there is a verbal report at the beginning of each shift, and staff listen to updates at that time. In a review of the facility 24-hour report sheet no documentation was found referencing R20's 7/21/15 care plan change to not leave R20 alone in her room in her wheelchair. A copy of the 24-hour report sheet with information on R20's 7/21/15 care plan change was requested but not received. In an interview on 9/3/15, at 11:18 a.m., the DON confirmed she did not see any reference to the care plan change in the 24-hour report sheets. LACK OF SECURED GRAB BARS FOR RESIDENT SAFETY WITH USE:	2 830		

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2 830	Continued From page 13 R32's Admission Record indicated diagnoses including dementia, osteoporosis, and pain. R32's Annual Minimum Data Set (MDS), dated 7/10/15, indicated R32 had severely impaired cognition, required extensive assistance for bed mobility and transfers and was unsteady when moving from sitting to standing. R32's Mobility Care Plan indicated impaired mobility related to generalized weakness, history of left hip fracture and rib fractures requiring assistance with bed mobility, transfers and wheelchair locomotion. An approach dated 7/22/15, directs staff to provide physical assist of 1-2 staff with bed mobility and transfers; R32's compliance varies as and staff are to use an EZ stand for transfers On 8/31/15, at 5:42 p.m., the right hand grab bar on R32's bed found to be easily moved from side to side and securely attached to bed frame. In an interview on 9/2/15, at 7:41 a.m., Nursing Assistant (NA)-A stated she would tell the maintenance man if she found a loose grab bar. NA-A stated she routinely takes care of R32. In an interview on 9/2/15, at 8:02 a.m., Maintenance Director (MD)-A stated staff put work for him on a clip board that is kept at the nurse's station. MD-A stated he checks the clip board daily and he has not received any requests to fix grab bars. MD-A was asked to check R32's grab bar and when finding it loose, MD-A stated, "I guess I need to tighten that up." In an interview on 9/2/15, at 8:14 a.m., NA-B stated that R32 uses the grab bar to sit up. In a follow-up interview on 9/2/15, at 8:22 a.m., NA-A stated that R32 occasionally uses the grab bar to sit at the side of the bed, as part of	2 830		

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2 830	Continued From page 14 transferring out of bed. A grab bar policy was requested and received; the policy does not address maintenance or routine checking of grab bars. MOBILITY DEVICE USED INCORRECTLY: R3's quarterly Minimum Data Set (MDS) dated 7/16/15, identified R3 had moderate cognitive impairment, and used a walker for mobility. During observation on 8/31/15, at 2:34 p.m. R3 was seated on a Nova brand four wheeled walker in the hallway of the North Unit. R3 wheeled around the hallway while seated on the device while her arms were crossed with her elbows resting on the handles of the device. R3 was not holding onto the device for security when in motion. When observed on 9/1/15, at 9:27 a.m. R3 was again seated on the seat portion of her four wheeled walker in the doorway of the beauty shop conversing with other residents. R3 proceeded to wheel herself down the hallway towards the dining room while seated on the four wheeled walker. R3 again had her arms crossed and was not holding onto the walker for security. When interviewed on 9/2/15, at 12:59 p.m. licensed practical nurse (LPN)-D stated R3 sits on her four wheeled walker and pushes herself around "quite often." The staff had tried to educate her on safe use of walker, despite her moderate cognitive impairment, on not doing so, but it hadn't help and R3 continued to do it. LPN-D stated she was unaware of what the four wheeled walkers manufacturer advised regarding this practice, but added she felt it was unsafe to do because "She [R3] can easily fall" off the walker while it is in motion. Further, LPN-D	2 830		

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2 830	Continued From page 15 observed R3's four wheeled walker and stated it had a label fixed to the leg which read, "DO NOT use as a wheelchair or to transport someone...lock hand brakes when sitting or while seated." During interview on 9/2/15, at 1:15 p.m. the director of nursing (DON) stated staff should be reminding R3 that it is unsafe to move herself around while seated on the walker "because its dangerous." Furthermore, the DON added, therapy should of been contacted and an evaluation would have been completed for R3's mobility. An undated Nova Rolling Walker User Guide read, "Safety Warning Instructions" which included, "DO NOT use as a wheelchair or to transport someone", and, "DO NOT self propel or scoot around while seated." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review the facility policy for assessment of resident smoking, and make any needed changes to reflect current regulations for safety. The DON could in-service staff on using mobility devices only as directed by the manufacturer instructions, and about how to correctly implement a residents plan of care. The DON could then audit these to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the	2 900		9/24/15

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2 900	Continued From page 16 comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and develop interventions to reduce the risk of pressure ulcer development for 1 of 3 residents (R57) reviewed for pressure ulcers and who had redness on their spine and sacrum. Findings include: R57's admission Minimum Data Set (MDS) an assessment tool dated 7/14/15, identified R57 had intact cognition, required limited assistance with transfers and bed mobility, and was at risk of pressure ulcer development but had no current pressure ulcers. R57's Pressure Ulcers Care Area Assessment dated 7/14/15, identified R57 had no current pressure ulcers or redness on his skin, but was at risk for pressure ulcer development related to his poor nutrition especially in the areas of "bony	2 900	Completed on 09/24/2015	

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2 900	Continued From page 17 prominences." R57's most recent Braden Scale For Predicting Pressure Sore (ulcer) Risk assessment dated 7/29/15, identified R57 to be "AT RISK" of pressure ulcer development, but did not identify R57 to have any current ulcers at the time. R57's progress notes dated 7/11/15, identified R57 "c/o [complained of] pain in coccyx and it was red...he [R57] wants an air bed...in other nursing home he had air bed and he did not break down." An additional note dated 7/20/15 and nine days late after 7/11/15 progress note, identified an, "Assessed sacral area ... has some blanchable redness ... has prominent bony prominences ... measures approximately 5 cm [centimeters] X [by] 5 cm." The progress note added, "Will call MD [medical doctor] for order for dressing to protect area from skin breakdown." However, the noted did not identify any immediate interventions to reduce R57's risk of pressure ulcer development. Furthermore, on 7/25/15 and 14 days after initial identification of the developed redness found in progress note dated 7/11/15, progress note identified, "...complained of stinging on lower back...noted a couple of red areas on lower spine about the size of nickels." No further progress notes identified any comprehensive assessment of R57's newly developed redness on his sacrum and spine, nor any interventions to be out in place to reduce the risk of worsening or new pressure ulcer development. During interview on 9/1/15, at 2:55 p.m. R57 stated he still had redness on his spine and sacrum as it was the "bony part" of his buttocks. R57 stated he develops redness on his sacrum and spine "from time to time", and was applying some various creams from his bedside table to	2 900		

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2 900	Continued From page 18	2 900		

them when he noted them. Further more, R57 added he had requested to have an air mattress placed on his bed to reduce the redness and risk of pressure ulcer development, but was told "they [facility] didn't have one."

R57's care plan dated 7/20/15, identified R57 was "at risk for pressure ulcers related to poor nutrition and friction, and listed a goal for R57 of having his skin remain intact. The care plan did not identify R57 to have any current redness or pressure ulcers.

When interviewed on 9/1/15, at 3:19 p.m. nursing assistant (NA)-G stated R57 was "pretty much independent" with his cares, and had no current pressure ulcers that she was aware of.

During interview on 9/2/15, at 8:18 a.m. registered nurse (RN)-A stated R57 had no current pressure ulcers, but did develop redness on his buttocks and spine "at times." Further, R57 would request creams be applied to these developed red areas at times, and staff encouraged him to reposition frequently.

When interviewed on 9/2/15, at 8:26 a.m. the director of nursing (DON) stated she was unaware of any developed redness on R57's sacrum or spine, and stated, "[I] haven't had anything reported to me." The DON was unaware R57 had requested an air bed to prevent skin breakdown and when sharing this with the DON she said, "That's the first I've heard of it."

During observation and subsequent interview on 9/2/15, at 8:45 a.m. the DON and the surveyor viewed R57's sacrum and spine. R57 had an area of redness on his sacrum that was approximately 4 inches in size, with a center of

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2 900	Continued From page 19 non-blanchable redness which the DON measured at "three by two and a half [centimeters]", along with some red areas on his vertebrae (spine) which were blanchable when pushed on. The DON stated R57 should have an air bed in place to reduce his risk of pressure ulcer development as he "definitely has potential to breakdown." Further, The DON stated R57 had not been comprehensively re-assessed for pressure ulcer risk since the most recent Braden Scale (7/29/15) as she was not aware R57 was developing these areas of redness on his sacrum and spine. On 9/3/15, at 9:04 a.m. the DON stated she had consulted with a wound nurse, and had been told R57 should have a daily application of skin repair cream. Furthermore, the DON stated she reviewed R57's medical record and R57 had not been re-assessed for pressure ulcer development since developing the redness on his sacrum and spine, "I do not see it", but added, R57 should have been re-assessed. An undated facility Policy and Procedure for the Prevention and Treatment of Skin Breakdown read, "It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity .. [and] to implement preventative measures..." Further, the policy directed staff to complete a "Comprehensive Evaluation of Skin Risk Factors" for a newly developed pressure ulcer. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could in-service nursing staff regarding how to promptly identify potential pressure ulcer development and implementation of the facility protocol to promote healing of current pressure ulcers. The DON could then audit to ensure compliance.	2 900		

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2 900	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess 1 of 3 residents (R3) reviewed for urinary incontinence and had a change in continence function. Findings include: R3's admission Minimum Data Set (MDS) dated 4/15/15, indicated R3 had moderate cognitive impairment, was always continent of urine and had no urinary toileting program. A review of R3's	2 910	Completed on 09/24/2015	9/24/15

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2 910	Continued From page 21 Quarterly MDS dated 7/16/15, indicated the resident had moderately impaired cognitive impairment, was occasionally incontinent of urine and had no urinary toileting program. R3's current care plan dated 8/6/15, identified R3 as being continent of bladder. The target goal for R3 is to remain continent of bladder through the next review. Interventions that were put in place were to have episodes of incontinence reported to the nurse and chart in the point of care a computerized charting program. R3's most recent Bladder Assessment, dated 6/18/15, indicated that R3 was continent of bladder. 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. When interviewed on 9/2/15, at 9:32 a.m., Nursing Assistant (NA)-E stated that he sometimes has to change R3's bedding due to incontinence. When interviewed on 9/2/15, at 1:47 p.m., R3 stated that she soils her underwear with urine at least half the time prior to going to the toilet. She stated that she had told the nurse in the past whenever her bedding was soiled and needed to be changed. R3 stated that her urinary incontinence happened mostly at night but occasionally during the day. When interviewed on 9/3/15, at 9:49 a.m., licensed practical nurse (LPN)- B, stated that the	2 910		

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2 910	Continued From page 22 nursing assistants are supposed to report to the nursing staff any instances of incontinence. She stated that she is not aware of ever being told of R3's urinary incontinence episodes. When interviewed on 9/3/15, at 11:13 a.m., R3 stated that she did have an episode of urinary incontinence this morning. However, this was not reported to the licensed nurse by NA's. When interviewed on 9/3/15, at 1:23 p.m., the Director of Nursing (DON) stated that she was not aware that the resident had episodes of urinary incontinence. She stated that if the resident had episodes of urinary incontinence that is something that staff should report right away. She stated that the nursing assistants should have notified the nursing staff. She stated that she would have expected a bladder assessment to have been done if the resident had an episode of urinary incontinence. When interviewed on 9/3/15, at 1:51 p.m., NA-F stated that if a resident had an episode of urinary incontinence she would first document it in the computerized chart and then let the nurse know. She stated that she did notice at least one time where R3 did have an episode of urinary incontinence where the resident had soiled pants that needed to be changed but no could not remember the date. After review of the facility policy titled, Bladder and Bowel Assessment Policy and Procedure dated 9/22/15, it stated that it is the policy of Adams Health Care Center that the facility will ensure that each resident that is incontinent of bladder and /or bowel is identified and assessed, given the opportunity to achieve continence or restore as much normal bladder and/or bowel	2 910		

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2 910	Continued From page 23 function as possible. A Bladder and Bowel Assessment will be completed annually or if a significant change in continent status is identified. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review the facility policy and procedure for newly identified incontinence, make necessary changes to reflect current regulations, and then in-service staff regarding the facility policy and procedure(s). The DON could then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur	21530		9/18/15

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21530	Continued From page 24 with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the consulting pharmacist failed to identify missing follow up recommendations from a psychiatric evaluation for 1 of 2 R12 reviewed for unnecessary medications. Findings include: R12 had been admitted according to the current physician orders R12 was admitted to the facility with diagnosis including anxiety and insomnia. The physician orders also identified R12 as receiving the medications clonazepam (antianxiety medication) and Trazodone (antidepressant medication used for insomnia). A psychiatric evaluation was ordered by the physician due to increased anxiety and behaviors and an evaluation was attempted on 5/28/15. There was no evaluation found in the record and	21530	Completed on 09/18/2015	

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21530	Continued From page 25 upon asking for it's location it was faxed from the psychiatrist to the facility on 9/3/15. Review of the referral form from the appointment read, "attempted neurocognitive testing, although R12 was not able to focus well at all. Will attempt further testing if he is more alert." A new diagnosis of cognitive disorder was identified. 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 medication] would be an ideal medication to be used, starting the doses of 7.5 mg, increasing it to potentially 15 to 30 mg as needed to help with sleep as well as with anxiety. I understand that a number of problematic behaviors have being noticed at night and based on current evidence, the current dose of clonazepam is not being helpful, hence this should be an appropriate consideration." "From an anxiety/cognitive risk assessment perspective, i would recommend a gradually tapering the clonazepam from the current total 4 mg a day over a period of the next 4 weeks completely and stopped. In its place if anxiety remains an issue and symptomatic treatment is necessary, then small doses of quetiapine [antipsychotic medication] at 12.5 to 25 mg could be utilized." During an interview on 09/03/2015, at 10:11 a.m. licensed practical nurse (LPN)-A verified the recommendations from the psych eval had not been followed. She stated that the psych referral	21530		

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21530	Continued From page 26 was not scanned in to the facility and should have been. LPN-A stated if the nurse didn't get the referral back she should have called to get it. She stated apparently no one called about it so it didn't get addressed. She stated, this (the final report) was at the clinic and she had just requested it be faxed to them, the facility did not have it to determine what changes to R12 medication regimen needed changing. A policy regarding consult was requested and none provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could in-service the consulting pharmacist regarding the timely identification of medication regimen irregularities. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section	21535		9/24/15

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21535	Continued From page 27 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to monitor for significant adverse consequences of smoking cigarettes while wearing a nicotine patch for 1 of 1 resident (R62) who was on a smoking cessation program which included a nicotine patch and chose to smoke even though the nicotine patch had a warning in regards to smoking while wearing the patch and failed to follow up on recommendations from a psychiatric evaluation timely for 1 of 2 residents (R12) reviewed for unnecessary medications. Findings include: LACK OF ASSESSMENT TO DETERMINE IF ADVERSE AFFECTS WERE IMMANENT FOR USE OF NICOTINE PATCH AND SMOKING AT THE SAME TIME: R62 was admitted to the facility on 7/28/15 with diagnoses to include: acute respiratory failure, obstructive chronic airway, difficulty in walking, muscle weakness, memory loss, and tobacco use disorder. R62 had a guardian appointed to her through Mower County.	21535	Completed on 09/24/2015	

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21535	Continued From page 28 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. Review of R62's Medication Administration Record (MAR) revealed an order for "nicotine patch; 21 mcg/24, apply patch transdermally one time a day. Remove old patch before placing new patch on." R62's MAR indicated R62 was administered the nicotine patch daily 8/1/15 through 9/2/15. 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. 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." Review of R62's progress notes revealed notations of R62 observed smoking on: 8/3/15, 8/6/15, 8/9/15, 8/17/15, and 8/30/15. Furthermore, there was no information documented nor provided in regards to the nicotine patch having been removed, nor if the physician had been informed of the resident smoking while wearing the nicotine patch. On 09/01/15 at 3:49 p.m. social services (SS)-A was interviewed regarding R62 smoking and said, "She [R62] is not supposed to be smoking at all because she is wearing a nicotine patch. With her memory she doesn't remember what we have	21535		

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talked about. The director of nursing has tried to explain that to her. If we catch her smoking we redirect her into the facility and don't let her finish her cigarette."

On 9/3/15 at 9:00 a.m. the director of nursing (DON) stated R62 wore a nicotine patch but did not know if the nicotine patch was removed when R62 was known to have been smoking.

Nicotine patch warnings from the Food and Drug Administration, dated 1/2010 read, "Do not use if you continue to smoke, chew tobacco, use snuff, use nicotine gum, or use another patch or other nicotine containing products...When using this product do not smoke even when not wearing the patch. The nicotine in your skin will still be entering the bloodstream for several hours after you take off the patch."

Nicotine patch directions include"...stop smoking completely when you being using the patch."

LACK OF TIMELY MEDICATION ADJUSTMENT FOLLOWING PSYCHIATRIC RECOMMENDATIONS:

R12 had been admitted according to the current physician orders R12 was admitted to the facility with diagnosis including anxiety and insomnia. The physician orders also identified R12 as receiving the medications clonazepam (antianxiety medication) and Trazodone (antidepressant medication used for insomnia).

A psychiatric evaluation was ordered by the physician due to increased anxiety and behaviors and an evaluation was attempted on 5/28/15. There was no evaluation found in the record and upon asking for it's location it was faxed from the

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21535	Continued From page 30	21535		

psychiatrist to the facility on 9/3/15. Review of the referral form from the appointment read, "attempted neurocognitive testing, although R12 was not able to focus well at all. Will attempt further testing if he is more alert." A new diagnosis of cognitive disorder was identified.

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 medication] would be an ideal medication to be used, starting the doses of 7.5 mg, increasing it to potentially 15 to 30 mg as needed to help with sleep as well as with anxiety. I understand that a number of problematic behaviors have being noticed at night and based on current evidence, the current dose of clonazepam is not being helpful, hence this should be an appropriate consideration." "From an anxiety/cognitive risk assessment perspective, i would recommend a gradually tapering the clonazepam from the current total 4 mg a day over a period of the next 4 weeks completely and stopped. In its place if anxiety remains an issue and symptomatic treatment is necessary, then small doses of quetiapine [antipsychotic medication] at 12.5 to 25 mg could be utilized."

During an interview on 09/03/2015, at 10:11 a.m. licensed practical nurse (LPN)-A verified the recommendations from the psych eval had not been followed. She stated that the psych referral was not scanned in to the facility and should have

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21535	Continued From page 31 been. LPN-A stated if the nurse didn't get the referral back she should have called to get it. She stated apparently no one called about it so it didn't get addressed. She stated, this (the final report) was at the clinic and she had just requested it be faxed to them, the facility did not have it to determine what changes to R12 medication regimen needed changing. A policy regarding consult was requested and none provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff regarding the implementation of medical provider recommendations with respect to psychotropic medications. The DON could then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation & interview, the facility failed to ensure the exhaust vents were cleaned to maintain a sanitary bathroom environment in 17 out of 23 bathrooms (101, 102, 103, 105, 106, 107, 108, 109, 112, 114, 124, 125, 126, 128, 129, 131, and 135) used by residents who reside in bedrooms adjoining these bathrooms.	21665	Completed on 09/24/2015	9/24/15

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21665	Continued From page 32 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 fixtures (bathroom)..."	21665		

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21665	Continued From page 33 Policy and Procedure for Cleaning Vents, dated 1/15/15 read, "Each Monday housekeeping will take a duster and clean all bathroom vents in Adams Health Care Center. Staff will check off when done. Bi-Annually vents will be taken down by maintenance department and cleaned out good and repainted as needed. Duct work will be vacuumed out at this time." SUGGESTED METHOD OF CORRECTION: The director of maintenance or designee could review all side rails and/or grab bars to ensure proper fitment and review all bathrooms on an on-going basis for proper cleaning then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R15) observed during activities of daily living assistance was treated in a dignified manner with physical cares and verbal conversation.	21805	Completed on 09/24/2015	9/24/15

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21805	Continued From page 34 Findings include: R15's Physician Order Report indicated R15 had diagnoses that included dementia and osteoporosis. The Physician Order Report also indicated R15 was on acetaminophen (analgesic) twice a day and Tramadol (analgesic) three times a day for pain relating to multiple myeloma, in remission. R15's Admission assessment Minimum Data Set (MDS), dated 6/17/15 indicated R15 had severely impaired cognition. R15's Cognitive Loss/Dementia Care Plan directed staff to provide opportunities of independent decision making, "i.e. choosing clothes to wear." R15's Activities of Daily Living (ADL) Functional Rehabilitation Potential Care plan indicated that R15 had a self-care deficient related to generalized weakness and was unable to perform ADLs independently. R15's care plan directed staff to physically assist R15 one-on-one with grooming/hygiene, dressing, toileting and weekly bath. On 9/2/15, at 9:14 a.m., R15 was in front of her closet, near her doorway, pointing to a pink garment. Nursing Assistant (NA)-D approached and, in a sharp tone of voice, told R15 she didn't want to put on a housecoat, it was after breakfast. NA-D pulled the pink garment out of the closet and stated to R15, "Oh, it's a sweater. But it's over 80 outside!" NA-D referred to R15 several times during the interaction as "Hun." As NA-D was talking, she put R15's right arm into the pink top. NA-D then lifted R15's left arm up and quickly thrust R15's arm into the sleeve. R15 immediately said, "Oh!, is there anyone else working here? " In an interview on 9/2/15, at 1:35 p.m., NA-D stated that she is designated as a functional	21805		

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21805	Continued From page 35 mobility staff, and gets pulled to the floor at least twice a month (this was one of the times pulled to help residents with cares) and that is just part of the job. In an interview on 9/3/15, at 1:48 p.m., the Administrator and Director of Nursing, the Administrator stated that if a resident wants a sweater on, that is what should be done for the resident. A policy on staff burnout was requested but not received from the facility. An undated, unsigned policy was received on Quality of Life & Dignity which stated that residents shall be treated with dignity and respect at all times. The policy read, "Staff shall speak respectfully to resident at all times, including addressing the resident by his or her name of choice." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could in-service staff regarding respectful interaction with staff and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		