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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: V78K

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00405

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245547**

2.STATE VENDOR OR MEDICAID NO.
(L2) **292923000**

3. NAME AND ADDRESS OF FACILITY
(L3) **ADRIAN CARE CENTER INC**
(L4) **603 LOUISIANA AVENUE**
(L5) **ADRIAN, MN** (L6) **56110**

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) **09/01/2009**

6. DATE OF SURVEY **04/19/2012** (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 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **30** (L18)

13.Total Certified Beds **30** (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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	30			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, HFE NEII 05/04/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 05/15/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1991 (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
04/11/2012 (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

CCN: 24-5547

A Post Certification Revisit (PCR) was completed by the Departments of Health and Public Safety to verify correction of deficiencies issued pursuant to the February 8, 2012. Based on the PCR, it has been determined that the facility has achieved substantial compliance pursuant to the February 8, 2012 standard survey, effective March 12, 2012. Refer to the CMS 2567b for both health and life safety code.

Effective March 12, 2012, the facility is certified for 30 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5547

May 15, 2012

Mr. Andrew Huhta, Administrator
Adrian Care Center Inc
603 Louisiana Avenue
Adrian, Minnesota 56110

Dear Mr. Huhta:

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

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

Effective March 12, 2012 the above facility is certified for:

30 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 30 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,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4118 Fax #: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 4, 2012

Mr. Andrew Huhta, Administrator
Adrian Care Center Inc
603 Louisiana Avenue
Adrian, Minnesota 56110

RE: Project Number F5547021

Dear Mr. Huhta:

On April 19, 2012, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 8, 2012. (42 CFR 488.417 (b))

Also, we notified you in our letter of April 19, 2012, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 8, 2012.

This was based on the deficiencies cited by this Department for a standard survey completed on February 8, 2012, and lack of verification of substantial compliance with the Life Safety Code (LSC) deficiencies at the time of our April 19, 2012 notice. The most serious LSC deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On April 19, 2012, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 8, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 15, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 8, 2012, as of March 12, 2012.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of April 19, 2012. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 8, 2012, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective May 8, 2012, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective May 8, 2012, is to be rescinded.

In our letter of April 19, 2012, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 8, 2012, due to denial of payment for new admissions. Since your facility attained substantial compliance on March 12, 2012, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

Feel free to contact me if you have questions.

Sincerely,

Maria King, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (507) 344-2716 Fax: (507) 344-2723

Enclosure

cc: Licensing and Certification File

5547r212.rtf

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 7312

April 19, 2012

Mr. Andrew Huhta, Administrator
Adrian Care Center Inc
603 Louisiana Avenue
Adrian, MN 56110

RE: Project Number S5547021

Dear Mr. Huhta:

On February 28, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 8, 2012. 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 March 29, 2012, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 8, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 15, 2012. Based on our visit, we have determined that your facility has achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on February 8, 2012.

However, compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the February 8, 2012 standard survey has not yet been verified. The most serious LSC deficiencies in your facility at the time of the standard extended survey were found 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.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective May 8, 2012. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective May 8, 2012. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 8, 2012. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Adrian Care Center Inc is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 8, 2012. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Post Certification Revisit Form (CMS-2567B) from the March 29, 2012 revisit is enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 8, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Maria King, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (507) 344-2716 Fax: (507) 344-2723

Enclosure

cc: Licensing and Certification File 5547r12_70day.rtf

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
245547	A. Building B. Wing	3/29/2012

Name of Facility	Street Address, City, State, Zip Code
ADRIAN CARE CENTER INC	603 LOUISIANA AVENUE ADRIAN, MN 56110

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	Correction Completed **02/12/2012**	ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **03/09/2012**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/12/2012**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **03/09/2012**	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	Date:	Signature of Surveyor:	Date:
	MM/MK	04/17/2012	03048	03/29/2012
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/8/2012				

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
245547	A. Building B. Wing **01 - MAIN BUILDING 01**	4/19/2012

Name of Facility	Street Address, City, State, Zip Code
ADRIAN CARE CENTER INC	603 LOUISIANA AVENUE ADRIAN, MN 56110

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	Correction Completed **02/28/2012**	ID Prefix	Correction Completed **02/20/2012**	ID Prefix	Correction Completed **02/09/2012**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0052		LSC K0062		LSC K0069	
ID Prefix	Correction Completed **02/16/2012**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0144		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	**Reviewed By** MM/PS	**Date:** 05/04/2012	**Signature of Surveyor:** 22373	**Date:** 04/19/2012
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/8/2012

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 A. Building B. Wing	(Y3) Date of Revisit
245547	02 - 2009 LINK TO ASSISTED LIVING	4/19/2012

Name of Facility	Street Address, City, State, Zip Code
ADRIAN CARE CENTER INC	603 LOUISIANA AVENUE ADRIAN, MN 56110

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0052	02/28/2012	ID Prefix Reg. # NFPA 101 LSC K0062	02/20/2012	ID Prefix Reg. # NFPA 101 LSC K0144	02/16/2012
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PS	05/04/2012	22373	04/19/2012
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/8/2012

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 19, 2012

Mr. Andrew Huhta, Administrator
Adrian Care Center Inc
603 Louisiana Avenue
Adrian, Minnesota 56110

Re: Enclosed Reinspection Results - Project Number S5547021

Dear Mr. Huhta:

On March 29, 2012 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 8, 2012. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Please feel free to call me with any questions.

Sincerely,

Maria King

Maria King, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (507) 344-2716 Fax: (507) 344-2723

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5547r12lic.rtf

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00405	A. Building B. Wing	3/29/2012

Name of Facility	Street Address, City, State, Zip Code
ADRIAN CARE CENTER INC	603 LOUISIANA AVENUE ADRIAN, MN 56110

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20265** Reg. # **MN Rule 4658.0085** LSC	Correction Completed **03/29/2012**	ID Prefix **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	Correction Completed **03/29/2012**	ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1** LSC	Correction Completed **03/29/2012**
ID Prefix **21942** Reg. # **MN St. Statute 144A.10 Su** LSC	Correction Completed **03/29/2012**	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	Date:	Signature of Surveyor:	Date:
	MM/MK	04/17/2012	03048	03/29/2012
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/8/2012

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: V78K

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00405

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245547**
2.STATE VENDOR OR MEDICAID NO.
(L2) **292923000**

3. NAME AND ADDRESS OF FACILITY
(L3) **ADRIAN CARE CENTER INC**
(L4) **603 LOUISIANA AVENUE**
(L5) **ADRIAN, MN** (L6) **56110**

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) **09/01/2009**

6. DATE OF SURVEY **02/08/2012** (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 IMR**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **30** (L18)

13.Total Certified Beds **30** (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	IMR
	30			
(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):
At the time of the February 8, 2012 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Kathy Hahn , HFE NEII 04/06/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 04/10/2012 (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
02/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 4/11/2012 ML

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

Certified Mail # 7010 2780 0001 4939 6070

February 28, 2012

Mr. Andrew Huhta, Administrator
Adrian Care Center Inc
603 Louisiana Avenue
Adrian, MN 56110

RE: Project Number S5547021

Dear Mr. Huhta:

On February 8, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

Telephone: (507) 344-2716

Fax: (507) 344-2723

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 19, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 19, 2012 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 8, 2012 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 8, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

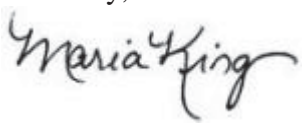
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Maria King, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (507) 344-2716 Fax: (507) 344-2723

Enclosure

cc: Licensing and Certification File 5547s12.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245547	A. BUILDING _____ B. WING _____	02/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADRIAN CARE CENTER INC	603 LOUISIANA AVENUE ADRIAN, MN 56110

(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 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.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156	Plan of Correction Approved Mtg 3/14/12 Resident #10's Medicare denial letter was signed and entered on 2/12/2012. The facility policy and procedure in the admission process has been reviewed and revised to ensure compliance with the 48 hour notice. The resident services coordinator and nursing staff have been educated on the requirement to provide Medicare Part A denial letters at least 48 hours in advance of the last covered day. The facility QA&A committee will review completed audits and make further recommendations. Corrective action was completed on February 12, 2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Andrew C. Hubka — TITLE: Administrator — (X6) DATE: 3/14/2012

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.

RECEIVED
MAR 15 2012
Minnesota Dept of Health
Mankato

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F 156	Continued From page 1	F 156		

inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and

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F 156	Continued From page 2 misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Notice of Medicare beneficiary's rights to appeal and expedited appeal upon termination of Medicare benefits for 1 of 3 residents (R10) in the sample who was reviewed for Liability and Beneficiary	F 156		

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F 156	Continued From page 3 Rights. Findings include: R10 was not provided the Notice of Medicare Provider non-coverage to inform the beneficiary of his right to request a review of services following termination of his Medicare Part A services for coverage reasons. During the Liability Notice & Beneficiary Appeal Rights Review conducted at 2:00 p.m. on 2/7/12, the LSW (licensed social worker) verified R10 did not receive the appropriate denial of Medicare coverage form required when the resident's Medicare coverage was discontinued on 9/2/11. The LSW stated the resident had qualified for Medicare coverage following a hospitalization on 8/29/11 for observation related to diagnosis of an urinary tract infection. On 9/2/11 the resident no longer had symptoms and no longer required skilled observation. At that time, the facility discontinued the resident's Medicare coverage as payment for the resident's stay. The LSW confirmed that she was unable to find any documentation that R10 had been given the appropriate appeal notice prior to or after the resident had been denied the Medicare coverage. The appeal notice would have informed the resident of his right to a review of Medicare coverage.	F 156		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an	F 157		

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F 157	Continued From page 4 accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow up with the physician in a timely manner regarding laboratory test results, and failed to notify the resident's family/ representative regarding a change in the resident's condition for 1 of 1 (R17) residents reviewed who had a change in condition. Findings Include:	F 157	It is the policy of Adrian Care Center to inform each resident; consult with the resident's physician and if known, notify the residents' legal representative or an interested family member when there is a significant change in the residents' physical, mental or psychosocial or clinical condition, or if their treatement is altered significantly. The resident services coordinator and nursing staff have been educated on the requirement to notify the residents' legal representative and/or family members when there is a significant change in resident's physical, mental or psychosocial or clinical condition, or alter treatment significantly.	

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F 157	Continued From page 5 R17 had a urinary tract infection (UTI) confirmed by urine culture results on 11/28/11. The physician was out of the office until 12/12/11 and there was no on-call service to review incoming documents. The facility did not follow up with the physician or clinic to ensure the lab results were reviewed in a timely manner. In addition, the resident's wife was not notified of the laboratory results, or subsequent physician order for an antibiotic. During a family interview with R17's wife on 2/6/11 at 5:00 p.m., R17's wife stated staff had not informed her about an UTI her husband was treated for. She stated she had noticed staff giving her husband a different medication and had asked what the medication was for and had been told it was to treat a UTI. R17's wife stated she was upset because the staff had not called her to notify her that her husband had the UTI or that he had been started on a new medication to treat it. The wife stated she is in the facility on almost a daily basis and was not notified until after she had asked about the medication they were giving him. R17's record was revealed. The resident had been admitted to the facility on 12/11/09 with diagnoses including: Parkinson's disease, adenocarcinoma of prostate, neurogenic bladder, hypertension, anemia, anxiety and dementia. The resident's admission face sheet dated 9/9/10 indicated his wife wife as the emergency contact, responsible party, and as responsible for R17's account statements. The interdisciplinary progress notes, physician notes, and physician's progress notes all reflect R17's wife as very involved in the resident's daily care, including assisting him with decision making about health	F 157	The Director of Nursing and Resident Services Coordinator will audit compliance with the Matrix system to ensure proper notification has occurred. Verbal reminders and corrections will be provided when notification did not take place and the DON will be informed. The DON has implemented a Doctor's Order Check List for orders on 3/9/2012. The facility QA&A committee will review completed audits and make further recommendations. Corrective action was completed on March 09, 2012.	

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F 157	Continued From page 6 concerns, and visiting daily. Review of the nurses' notes dated 12/12/11, revealed an entry by the director of nursing (DON) which included: "Received order from Dr (doctor)... for a urinalysis (U/A) we sent in around 11/28/11. She has been out of the office at the Veterans (VA) and apparently they do not have on call service to manage her paper work when she is not here. Macrobid (an antibiotic) x 10 days twice a day (BID). Continue Gentamycin." Review of the physician's order dated 12/12/11, verified the order for Macrobid 100 mg (milligrams) 1 tablet twice a day (BID) for 10 days. The record failed to indicate whether the wife had been notified following receipt of the order. During an interview with the DON on 2/7/12 at 10:00 a.m., the DON verified there was no documentation in the progress notes that R17's wife had been notified about the resident's urinary tract infection or the prescription treatment. The DON also confirmed the facility had not followed up with the physician to ensure the laboratory values had been reviewed in a timely manner for R17. The DON confirmed treatment had not been initiated until after the physician's return to the office on 12/12/11.	F 157		
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.	F 329	Resident #4's drug regimen has been reviewed and revised to address the use of Risperdal. The comprehensive plan of care has been reviewed and revised on 2/8/2012.	

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F 329	Continued From page 7 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. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to adequately identify clinical indications for use of medications for 1 of 3 residents (R4) in the sample reviewed for the use of psychoactive medications. The findings include: R4 had received Risperdal (an antipsychotic medication) daily since November 2011 without adequate clinical indications for use. R4's record was reviewed and revealed the resident had been admitted to the facility 7/13/11 with diagnoses that included: depressive disorder and diabetes type I complicated by retinopathy and blindness. A review of the nurses' notes indicated the resident had begun to exhibit behaviors including: throwing things in room,	F 329	All current residents' drug regimens have been reviewed to ensure that they are fre of unnecessary drugs. A new Doctor's Check List has been implemented to check for proper medications and appropriate diagnosis. The Director of Nursing has reeducated nursing staff on the facility policy and procedures regarding appropriate administration of medications. The DON or Resident Services Coordinator will audit the Doctor Check List for compliance on a weekly basis to assess for trends and to make recommendations regarding the need for further corrections. The facility QA&A committee will audit quarterly and make further recommendations. Corrective action was completed on March 15, 2012.	

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F 329	Continued From page 8	F 329		

verbally inappropriate, yelling and swearing in hallways, attempting to climb out windows, pulled air freshener off wall, "trashed" bathroom, pulling emergency alarm, pulled emergency alarm off wall, threw cane against window, and swinging his cane at staff a couple of months after admission. On 11/29/11, nursing staff had recieved an order from the resident's physician for Risperdal 0.25 mg (milligrams) PRN (as needed). In addition they had scheduled the resident for a psychiatric evaluation. On 11/30/11, the physician had approved the use of the Risperdal 0.25 mg twice a day routinely. Although the resident displayed inappropriate behaviors, the physician's orders and a progress note from a 12/8/11 visit to R4 failed to identify any clinical diagnosis, and failed to address the resident's behaviors or the use/response, for the antipsychotic medication.

A quarterly Minimum Data Set (MDS) dated 1/17/12, indicated R4 was cognitively intact, exhibited verbal behavioral symptoms daily and showed little interest or pleasure in doing things 2-6 times per week.

A psychological evaluation was conducted by a psychiatrist on 1/25/12. The psychiatrist's recommendations were for R4 to continue with medications as ordered. The psychiatrist did not identify any relevant diagnoses for the behaviors or use of the antipsychotic medication.

The director of nursing was interviewed on 2/8/12 at 9:00 a.m. She verified the resident's record failed to specifically indicate indications for use or relevant diagnosis for the use of the Risperdal. Following interview with the surveyor, the DON

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F 329	Continued From page 9 called the psychiatrist and received a diagnosis of Schizophrenia to put on R4's record.	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 facility failed to assure the consultant pharmacist identified and reported drug irregularities to the physician and director of nursing for 1 of 3 residents (R4) in the sample reviewed for psychoactive medication use. The findings include: R4 had received Risperdal (an antipsychotic medication) daily since November 2011 without adequate clinical indications for use. The pharmacist had not identified this irregularity. R4's record was reviewed and revealed the resident had been admitted to the facility 7/13/11 with diagnoses that included: depressive disorder and diabetes type I complicated by retinopathy and blindness. A review of the nurses' notes	F 428	The Adrian Care Center ensures that each residents' drug regimen is reviewed monthly by a licensed pharmacy consultant. The Director of Nursing called the psychiatrist on 2/8/2012 to receive the diagnosis of Schizophrenia to insert into R #4's record. The DON met with the consultant pharmacist on 2/10/2012 to discuss regimen of resident #4 as well as the facility policy regarding administration of unnecessary drugs. The consultant pharmacist will review all current residents' drug regimens monthly and will monitor for facility compliance with requirements for administration of medications with their proper dosage ranges and diagnosis. The Director of Nursing reeducated nursing staff on the facility policy and procedures regarding appropriate administration of medications on 3/9/2012. The DON or designee will do random audits to ensure correction is achieved and maintained.	

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F 428	Continued From page 10 indicated the resident had begun to exhibit behaviors including: throwing things in room, verbally inappropriate, yelling and swearing in hallways, attempting to climb out windows, pulled air freshener off wall, "trashed" bathroom, pulling emergency alarm, pulled emergency alarm off wall, threw cane against window, and swinging his cane at staff a couple of months after admission. On 11/29/11, nursing staff had recieved an order from the resident's physician for Risperdal 0.25 mg (milligrams) PRN (as needed). In addition they had scheduled the resident for a psychiatric evaluation. On 11/30/11, the physician had approved the use of the Risperdal 0.25 mg twice a day routinely. Although the resident displayed inappropriate behaviors, the physician's orders and a progress note from a 12/8/11 visit to R4 failed to identify any clinical diagnosis, and failed to address the resident's behaviors or the use/response, for the antipsychotic medication. A quarterly Minimum Data Set (MDS) dated 1/17/12, indicated R4 was cognitively intact, exhibited verbal behavioral symptoms daily and showed little interest or pleasure in doing things 2-6 times per week. A psychological evaluation was conducted by a psychiatrist on 1/25/12. The psychiatrist's recommendations were for R4 to continue with medications as ordered. The psychiatrist did not identify any relevant diagnoses for the behaviors or use of the antipsychotic medication. The consultant pharmacist reviewed R4's medication regimen on 12/21/11 and 2/2/12 and had not identified any irregularities related to the	F 428	The facility QA&A committee will audit quarterly and make further recommendations. Corrective action was completed on March 09, 2012.	

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F 428	Continued From page 11 use of the Risperdal. The director of nursing was interviewed on 2/8/12 at 9:00 a.m. She verified the resident's record failed to specifically indicate indications for use or relevant diagnosis for the use of the Risperdal.	F 428		

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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 on February 8, 2012. At the time of this survey, Building 01 of Adrian 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) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 ST. Paul, MN 55101-5145 Pat.Sheehan@state.mn.us	K 000	POC ok PS 4-6-12 RECEIVED MAR 16 2012 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 03.20.2012

EXIT: 02.08.2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Andrew C. Hubka — TITLE: Administrator — (X6) DATE: 3/14/2012

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. Adrian Care Center was constructed as follows: Building 01 - The original building was constructed in 1969, is one-story in height, has a partial basement, is fully fire sprinkler protected and is of Type II(000) construction; A building addition was constructed in 1976, it is one-story in height, has no basement, is fully fire sprinkler protected and is of Type II(000) construction. Building 02 - Consists of a link to an assisted living facility. It was built in 2009, is one-story in height, has no basement, is fully fire sprinkler protected and is of Type I(332) construction. There are no patient sleeping or treatment areas in Building 02. A two-hour fire wall separates the Nursing Home from an attached clinic, and the single communicating opening is protected by a labeled, self-closing, 90-minute fire-rated door assembly. Also, a two-hour fire wall with a labeled, self-closing, 90-minute fire-rated door assembly separates the 1969 building of Type II(000) construction from the 2009 addition of Type	K 000		

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K 000	Continued From page 2 I(332) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 30 beds and had a census of 20 at time of the survey. Because the original building and the new addition met the construction types allowed for both new and existing buildings, the facility was surveyed as two buildings, and two (2) Form CMS-2786R booklets were completed; Building 01 at Chapter 19 Existing Health Care Occupancies and Building 02 at Chapter 18 New Health Care Occupancies. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by:	K 052		

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K 052	Continued From page 3 NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with NFPA 70 National Electrical Code (1999 edition) and NFPA 72 National Fire Alarm Code (1999 edition). The system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70 (99) and NFPA 72 (99) and NFPA 101 Life Safety Code (2000 edition), Chapter 9, Section 9.6.1.4. FINDINGS INCLUDE: On 2/8/12 between 9:30 AM and 2:00 PM, during a review of available documentation provided by the chief building engineer, it was confirmed the facility's Digital Alarm Communicator Transmitter (DACT) was not tested during the months of September, October and December of 2011. The DACT must be tested monthly in accordance with CMS policy, as provided for at NFPA 72 (99) Chapter 7, Section 7-3.2. In a fire emergency, this deficient practice could adversely affect 30 of 30 residents, staff and visitors.	K 052	A fire drill was conducted on 2/28/2012 and contact was made with the Digital Alarm Communicator Transmitter. All fire drills will be conducted in a timely manner, and all monthly fire drills will have current documentation of contact with the Digital Alarm Communicator Transmitter. All monthly fire drills are the responsibility of the administrator and/or building engineer. Monthly fire drills will be submitted to the quarterly QA&A and safety committees to ensure compliance.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by:	K 062		

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K 062	Continued From page 4 NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met, based upon the following: Based on record review and interview, the facility failed to properly maintain the fire sprinkler system in accordance with NFPA 101 Life Safety Code (2000 edition), Chapter 19, Section 19.7.6 and Chapter 4, Section 4.6.12 and NFPA 25 (1998 edition). In a fire emergency, this deficient practice could adversely affect 30 of 30 residents, staff and visitors. FINDINGS INCLUDE: On 2/8/12 between 9:30 AM and 2:00 PM, during a review of available documentation provided by the chief building engineer, it was confirmed that quarterly flow tests of the fire sprinkler system had not been conducted during calendar year 2011. Quarterly flow tests are designed to test water flow alarm devices, pressure switches, water motor gongs and other required devices of a wet-pipe fire sprinkler system. This deficient practice was not in conformance with NFPA 25 (1998 edition) Chapter 2, Section 2-3 and Chapter 9, Section 9-2.	K 062	Fire sprinkler flow tests will be timely and documentation records will be kept up-to-date and in accordance with policies and procedures. A flow test will be conducted on February 20, 2012. All quarterly fire sprinkler flow tests are the responsibility of the facility building engineer. Quarterly sprinkler flow tests will be submitted to the QA&A and safety committees to ensure compliance.	
K 069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96	K 069		

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K 069	Continued From page 5 This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - Cooking facilities shall be protected and maintained in accordance with NFPA 101 (2000), Chapter 19, Section 19.3.2.6 and Chapter 9, Section 9.2.3. and NFPA 96 (1998). This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility prepared fried eggs on a portable griddle outside of the main dietary kitchen, using a vegetable oil spray which creates grease-laden vapors. These cooking operations were not protected by a Type-I range hood with a UL-300 automatic fire extinguishment system. In a fire emergency, this deficient practice could adversely affect 30 of 30 residents, staff and visitors within the involved smoke compartment. FINDINGS INCLUDE: A). On 2/8/12 between 9:30 AM and 2:00 PM, a Minnesota Department of Health [MDH] surveyor advised she had observed facility staff preparing fried eggs for residents, using a portable griddle located within the Resident Dining Room. This egg frying operation did involve the use of a vegetable oil spray to coat the surface of the griddle. Further investigation and an interview with the dietary manager confirmed this practice. When used to coat the surface of a griddle or frying pan, vegetable oil spray is a product which can create grease-laden vapors, and these cooking operations require protection by a Type-I range hood with a UL-300 automatic fire	K 069	A) Portable Griddles were pulled from service and dietary staff educated on 2/8/2012 the use of vegetable oil spray and noncompliance of a Type-I range hood with a UL-300 automatic fire extinguishing system. B) Educated Dietary staff that they cannot to use any vegetable oil spray with the current fire suppression system on 2/8/2012. A) On 2/8/2012, all portable griddles were taken out of service and will not be used in any areas of the facility. B) Dietary staff will not prepare fried eggs and/or grill foods using vegetable oil spray on the existing commercial oven. Dietary staff was educated on the location of the Ansul K-Guard fire extinguisher in the Main Dietary area. The Dietary Manager will monitor daily to ensure that all griddles continue to stay out of service and vegetable sprays not be used on the commercial oven. The Building Engineer, Administrator and Director of Nursing will also monitor weekly to ensure ongoing compliance.	3-9-12

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K 069	Continued From page 6 extinguishment system, in accordance with NFPA 96 (1998 edition) and MDH Policy. B). On 2/8/12 at 1:05 PM, during an inspection of the Main Dietary area, observation revealed a commercial oven equipped with a stove-top griddle. In an interview with the dietary manager, it was confirmed that fried eggs and grilled cheese sandwiches are prepared occasionally, using a vegetable oil spray to coat the griddle surface. This commercial oven/range/griddle was not protected by a Type-I range hood with a UL-300 automatic fire extinguishment system, in accordance with NFPA 96 (1998) and MDH policy.	K 069		
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: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - Generators must be inspected weekly and exercised under load at not less than 30% of the EPS nameplate rating, for 30 minutes per month and shall be in accordance with NFPA 99 (1999 edition) and NFPA 110 (1999 edition).	K 144		

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K 144	Continued From page 7 FINDINGS INCLUDE: On 2/8/12 between 9:30 AM and 2:00 PM, during a review of available records provided by the chief building engineer, no documentation could be provided verifying the emergency generator was exercised at not less than 30% of the EPS nameplate rating monthly, during calendar year 2011. This deficient practice was not in conformance with NFPA 110 (1999), Chapter 6, Section 6-4.2 and NFPA 99 (1999), Chapter 3, Section 3-4.4.1.1. In a fire or other emergency, this deficient practice could adversely affect 30 of 30 residents, staff and visitors.	K 144	The emergency generator was tested and exercised at not less than 30% of the EPS nameplate rating on 2/16/2012. A monthly emergency generator test was conducted on 2/16/2012 by Cummings Power Generation. The documentation of the monthly emergency generator is current. The Building Engineer will be responsible for continued monthly testing for compliance. Monthly emergency generator tests will be submitted to the quarterly QA&A and safety committees to ensure compliance.	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245547	A. BUILDING 02 - 2009 LINK TO ASSISTED I B. WING _____	02/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADRIAN CARE CENTER INC	603 LOUISIANA AVENUE ADRIAN, MN 56110

(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
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 on February 8, 2012. At the time of this survey, Building 02 of Adrian 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) 101 Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 ST. Paul, MN 55101-5145 Pat.Sheehan@state.mn.us	K 000	POC ok PS 4-6-12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Andrew C. Hubka	Administrator	3/26/2012

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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. Adrian Care Center was constructed as follows: Building 01 - The original building was constructed in 1969, is one-story in height, has a partial basement, is fully fire sprinkler protected and is of Type II(000) construction; A building addition was constructed in 1976, it is one-story in height, has no basement, is fully fire sprinkler protected and is of Type II(000) construction. Building 02 - Consists of a link to an assisted living facility. It was built in 2009, is one-story in height, has no basement, is fully fire sprinkler protected and is of Type I(332) construction. There are no patient sleeping or treatment areas in Building 02. A two-hour fire wall separates the Nursing Home from an attached clinic, and the single communicating opening is protected by a labeled, self-closing, 90-minute fire-rated door assembly. Also, a two-hour fire wall with a labeled, self-closing, 90-minute fire-rated door assembly separates the 1969 building of Type II(000) construction from the 2009 addition of Type	K 000		

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K 000	Continued From page 2 I(332) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 30 beds and had a census of 20 at time of the survey. Because the original building and the new addition met the construction types allowed for both new and existing buildings, the facility was surveyed as two buildings, and two (2) Form CMS-2786R booklets were completed; Building 01 at Chapter 19 Existing Health Care Occupancies and Building 02 at Chapter 18 New Health Care Occupancies. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with NFPA 70	K 052	A fire drill was conducted on 2/28/2012 and contact was made with the Digital Alarm Communicator Transmitter. All fire drills will be conducted in a timely manner, and all monthly fire drills will have current documentation of contact with the Digital Alarm Communicator Transmitter.	

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K 052	Continued From page 3 National Electrical Code (1999 edition) and NFPA 72 National Fire Alarm Code (1999 edition). The system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70 (99) and NFPA 72 (99) and NFPA 101 Life Safety Code (2000 edition), Chapter 9, Section 9.6.1.4. FINDINGS INCLUDE: On 2/8/12 between 9:30 AM and 2:00 PM, during a review of available documentation provided by the chief building engineer, it was confirmed the facility's Digital Alarm Communicator Transmitter (DACT) was not tested during the months of September, October and December of 2011. The DACT must be tested monthly in accordance with CMS policy, as provided for at NFPA 72 (99) Chapter 7, Section 7-3.2. In a fire emergency, this deficient practice could adversely affect 30 of 30 residents, staff and visitors.	K 052	All monthly fire drills are the responsibility of the administrator and/or building engineer. Monthly fire drills will be submitted to the quarterly QA&A and safety committees to ensure compliance.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and	K 062		

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K 062	Continued From page 4 tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met, based upon the following: Based on record review and interview, the facility failed to properly maintain the fire sprinkler system in accordance with NFPA 101 Life Safety Code (2000 edition), Chapter 18, Section 18.7.6 and Chapter 4, Section 4.6.12 and NFPA 25 (1998 edition). In a fire emergency, this deficient practice could adversely affect 30 of 30 residents, staff and visitors. FINDINGS INCLUDE: On 2/8/12 between 9:30 AM and 2:00 PM, during a review of available documentation provided by the chief building engineer, it was confirmed that quarterly flow tests of the fire sprinkler system had not been conducted during calendar year 2011. Quarterly flow tests are designed to test water flow alarm devices, pressure switches, water motor gongs and other required devices of a wet-pipe fire sprinkler system. This deficient practice was not in conformance with NFPA 25 (1998 edition) Chapter 2, Section 2-3 and Chapter 9, Section 9-2.	K 062	Fire sprinkler flow tests will be timely and documentation records will be kept up-to-date and in accordance with policies and procedures. A flow test will be conducted on February 20, 2012. All quarterly fire sprinkler flow tests are the responsibility of the facility building engineer. Quarterly sprinkler flow tests will be submitted to the QA&A and safety committees to ensure 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.	K 144		

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K 144	Continued From page 5 This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - Generators must be inspected weekly and exercised under load at not less than 30% of the EPS nameplate rating, for 30 minutes per month and shall be in accordance with NFPA 99 (1999 edition) and NFPA 110 (1999 edition). FINDINGS INCLUDE: On 2/8/12 between 9:30 AM and 2:00 PM, during a review of available records provided by the chief building engineer, no documentation could be provided verifying the emergency generator was exercised at not less than 30% of the EPS nameplate rating monthly, during calendar year 2011. This deficient practice was not in conformance with NFPA 110 (1999), Chapter 6, Section 6-4.2 and NFPA 99 (1999), Chapter 3, Section 3-4.4.1.1. In a fire or other emergency, this deficient practice could adversely affect 30 of 30 residents, staff and visitors.	K 144	The emergency generator was tested and exercised at not less than 30% of the EPS nameplate rating on 2/16/2012. A monthly emergency generator test was conducted on 2/16/2012 by Cummings Power Generation. The documentation of the monthly emergency generator is current. The Building Engineer will be responsible for continued monthly testing for compliance. Monthly emergency generator tests will be submitted to the quarterly QA&A and safety committees to ensure compliance.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 6070

February 28, 2012

Mr. Andrew Huhta, Administrator
Adrian Care Center Inc
603 Louisiana Avenue
Adrian, MN 56110

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5547021

Dear Mr. Huhta:

The above facility was surveyed on February 6, 2012 through February 8, 2012 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

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

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,

Maria King, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (507) 344-2716 Fax: (507) 344-2723

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On February 6th, 7th, and 8th 2012, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Certification Program; 12 Civic Center Plaza, Suite 2105, Mankato, Minnesota 56001.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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.	
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for:	2 265		

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2 265	Continued From page 2 A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to follow up with the physician in a timely manner regarding laboratory test results, and failed to notify the resident's family/ representative regarding a change in the resident's condition for 1 of 1 (R17) residents reviewed who had a change in condition. Findings Include: R17 had a urinary tract infection (UTI) confirmed by urine culture results on 11/28/11. The physician was out of the office until 12/12/11 and there was no on-call service to review incoming documents. The facility did not follow up with the physician or clinic to ensure the lab results were reviewed in a timely manner. In addition, the resident's wife was not notified of the laboratory	2 265		

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2 265	Continued From page 3 results, or subsequent physician order for an antibiotic. During a family interview with R17's wife on 2/6/11 at 5:00 p.m., R17's wife stated staff had not informed her about an UTI her husband was treated for. She stated she had noticed staff giving her husband a different medication and had asked what the medication was for and had been told it was to treat a UTI. R17's wife stated she was upset because the staff had not called her to notify her that her husband had the UTI or that he had been started on a new medication to treat it. The wife stated she is in the facility on almost a daily basis and was not notified until after she had asked about the medication they were giving him. R17's record was revealed. The resident had been admitted to the facility on 12/11/09 with diagnoses including: Parkinson's disease, adenocarcinoma of prostate, neurogenic bladder, hypertension, anemia, anxiety and dementia. The resident's admission face sheet dated 9/9/10 indicated his wife wife as the emergency contact, responsible party, and as responsible for R17's account statements. The interdisciplinary progress notes, physician notes, and physician's progress notes all reflect R17's wife as very involved in the resident's daily care, including assisting him with decision making about health concerns, and visiting daily. Review of the nurses' notes dated 12/12/11, revealed an entry by the director of nursing (DON) which included: "Received order from Dr (doctor)... for a urinalysis (U/A) we sent in around 11/28/11. She has been out of the office at the Veterans (VA) and apparently they do not have on call service to manage her paper work when she is not here. Macrobid (an antibiotic) x 10 days twice a day (BID). Continue Gentamycin." Review	2 265		

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2 265	Continued From page 4 of the physician's order dated 12/12/11, verified the order for Macrobid 100 mg (milligrams) 1 tablet twice a day (BID) for 10 days. The record failed to indicate whether the wife had been notified following receipt of the order. During an interview with the DON on 2/7/12 at 10:00 a.m., the DON verified there was no documentation in the progress notes that R17's wife had been notified about the resident's urinary tract infection or the prescription treatment. The DON also confirmed the facility had not followed up with the physician to ensure the laboratory values had been reviewed in a timely manner for R17. The DON confirmed treatment had not been initiated until after the physician's return to the office on 12/12/11. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could review and revise the policies and procedures regarding notification of a change in a resident's condition to family members and the physician. Nursing staff could be educated regarding the procedure. The quality assurance committee could randomly audit records to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 265		
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	21530		

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(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
21530	Continued From page 5 available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does 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 facility failed to assure the consultant pharmacist identified and reported drug irregularities to the physician and director of nursing for 1 of 3 residents (R4) in the sample reviewed for psychoactive medication use. The findings include:	21530		

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	00405	A. BUILDING _____ B. WING _____	02/08/2012

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21530	Continued From page 6 R4 had received Risperdal (an antipsychotic medication) daily since November 2011 without adequate clinical indications for use. The pharmacist had not identified this irregularity. R4's record was reviewed and revealed the resident had been admitted to the facility 7/13/11 with diagnoses that included: depressive disorder and diabetes type I complicated by retinopathy and blindness. A review of the nurses' notes indicated the resident had begun to exhibit behaviors including: throwing things in room, verbally inappropriate, yelling and swearing in hallways, attempting to climb out windows, pulled air freshener off wall, "trashed" bathroom, pulling emergency alarm, pulled emergency alarm off wall, threw cane against window, and swinging his cane at staff a couple of months after admission. On 11/29/11, nursing staff had recieved an order from the resident's physician for Risperdal 0.25 mg (milligrams) PRN (as needed). In addition they had scheduled the resident for a psychiatric evaluation. On 11/30/11, the physician had approved the use of the Risperdal 0.25 mg twice a day routinely. Although the resident displayed inappropriate behaviors, the physician's orders and a progress note from a 12/8/11 visit to R4 failed to identify any clinical diagnosis, and failed to address the resident's behaviors or the use/response, for the antipsychotic medication. A quarterly Minimum Data Set (MDS) dated 1/17/12, indicated R4 was cognitively intact, exhibited verbal behavioral symptoms daily and showed little interest or pleasure in doing things 2-6 times per week. A psychological evaluation was conducted by a	21530		

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21530	Continued From page 7 psychiatrist on 1/25/12. The psychiatrist's recommendations were for R4 to continue with medications as ordered. The psychiatrist did not identify any relevant diagnoses for the behaviors or use of the antipsychotic medication. The consultant pharmacist reviewed R4's medication regimen on 12/21/11 and 2/2/12 and had not identified any irregularities related to the use of the Risperdal. The director of nursing was interviewed on 2/8/12 at 9:00 a.m. She verified the resident's record failed to specifically indicate indications for use or relevant diagnosis for the use of the Risperdal. SUGGESTED METHOD FOR CORRECTION: The administrator, director of nursing and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage/diagnosis. Staff could be educated as necessary. The director of nursing or designee could monitor medications on a regular basis to ensure compliance with state and federal regulations. 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	21535		

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21535	Continued From page 8 which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for 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 interview and document review, the facility failed to adequately identify clinical indications for use of medications for 1 of 3 residents (R4) in the sample reviewed for the use of psychoactive medications. The findings include: R4 had received Risperdal (an antipsychotic medication) daily since November 2011 without adequate clinical indications for use. R4's record was reviewed and revealed the resident had been admitted to the facility 7/13/11 with diagnoses that included: depressive disorder and diabetes type I complicated by retinopathy and blindness. A review of the nurses' notes indicated the resident had begun to exhibit behaviors including: throwing things in room, verbally inappropriate, yelling and swearing in hallways, attempting to climb out windows, pulled	21535		

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21535	Continued From page 9 air freshener off wall, "trashed" bathroom, pulling emergency alarm, pulled emergency alarm off wall, threw cane against window, and swinging his cane at staff a couple of months after admission. On 11/29/11, nursing staff had recieved an order from the resident's physician for Risperdal 0.25 mg (milligrams) PRN (as needed). In addition they had scheduled the resident for a psychiatric evaluation. On 11/30/11, the physician had approved the use of the Risperdal 0.25 mg twice a day routinely. Although the resident displayed inappropriate behaviors, the physician's orders and a progress note from a 12/8/11 visit to R4 failed to identify any clinical diagnosis, and failed to address the resident's behaviors or the use/response, for the antipsychotic medication. A quarterly Minimum Data Set (MDS) dated 1/17/12, indicated R4 was cognitively intact, exhibited verbal behavioral symptoms daily and showed little interest or pleasure in doing things 2-6 times per week. A psychological evaluation was conducted by a psychiatrist on 1/25/12. The psychiatrist's recommendations were for R4 to continue with medications as ordered. The psychiatrist did not identify any relevant diagnoses for the behaviors or use of the antipsychotic medication. The director of nursing was interviewed on 2/8/12 at 9:00 a.m. She verified the resident's record failed to specifically indicate indications for use or relevant diagnosis for the use of the Risperdal. Following interview with the surveyor, the DON called the psychiatrist and received a diagnosis of Schizophrenia to put on R4's record. SUGGESTED METHOD FOR CORRECTION:	21535		

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21535	Continued From page 10 The Director of Nursing or designee could develop policies and procedures, educate staff, and conduct random audits of resident medication regimens to ensure compliance with state and federal regulatory requirements. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21535		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview, the facility failed to attempt to establish a family council during the past calendar year. The findings include: During an interview with the LSW (Licensed Social Worker) at 2:00 p.m on 2/7/12, she indicated that there had been no active family council in the past year. She also verified that there had been no attempts by the facility to establish a family council during the past year.	21942		

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21942	Continued From page 11 SUGGESTED METHOD OF CORRECTION: The administrator or designee could delegate an individual to be responsible for the annual attempt to establish a family council/group. That individual would need to document it's efforts at forming a council, and identify when the attempt occurred in the calendar year. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21942		