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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: VKJ2
Facility ID: 00255

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245289**

2. STATE VENDOR OR MEDICAID NO. (L2) **604140000**

3. NAME AND ADDRESS OF FACILITY
(L3) **CRYSTAL CARE CENTER**
(L4) **3245 VERA CRUZ AVENUE NORTH**
(L5) **CRYSTAL, MN** (L6) **55422**

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) **11/30/2002**

6. DATE OF SURVEY 12/06/2013 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **06/30**

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

12. Total Facility Beds **130** (L18)

13. Total Certified Beds **130** (L17)

10. THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

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

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

* Code: **A5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	130			
(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 :
Gloria Derfus, Unit Supervisor 12/06/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 02/06/2014 (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 **11/01/1984** (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 **01/16/2014** (L33)

DETERMINATION APPROVAL

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

CCN-245289

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility had achieved and maintained compliance with Federal Certification Regulations. Effective December 3, 2013, the facility is certified for 130 skilled nursing facility beds.

The facility's request for a continuing waiver of K67 has been forwarded to the CMS RO for review and approval.

Please refer to the CMS 2567B.

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5289 February 6, 2014

Mr. Dean McDevitt, Administrator
Crystal Care Center
3245 Vera Cruz Avenue North
Crystal, Minnesota 55422

Dear Mr. McDevitt:

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 December 3, 2013, the above facility is certified for:

130 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 130 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,

Colleen Leach

Colleen B. Leach, 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)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245289	A. Building B. Wing	12/6/2013

Name of Facility	Street Address, City, State, Zip Code
CRYSTAL CARE CENTER	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

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 **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	**11/29/2013**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	**11/29/2013**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	**11/29/2013**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	**11/29/2013**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**11/29/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	**11/29/2013**
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 State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/GD	12/06/2013	18623	12/06/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/25/2013

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

OHFC

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245289	A. Building B. Wing	12/3/2013

Name of Facility	Street Address, City, State, Zip Code
CRYSTAL CARE CENTER	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

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 F0323 Reg. # 483.25(h) LSC	12/03/2013	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		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By MM/KL	Date: 12/24/2013	Signature of Surveyor: 31242	Date: 12/03/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/24/2013	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00255	A. Building B. Wing	12/3/2013

Name of Facility	Street Address, City, State, Zip Code
CRYSTAL CARE CENTER	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

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 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	Correction Completed 12/03/2013	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/KL	12/24/2013	31242	12/03/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/24/2013

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

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: VKJ2
Facility ID: 00255

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245289**

2. STATE VENDOR OR MEDICAID NO. (L2) **822042500**

3. NAME AND ADDRESS OF FACILITY
(L3) **CRYSTAL CARE CENTER**
(L4) **3245 VERA CRUZ AVENUE NORTH**
(L5) **CRYSTAL, MN** (L6) **55422**

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) **11/30/2002**

6. DATE OF SURVEY **10/25/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **06/30**

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

12. Total Facility Beds **130** (L18)

13. Total Certified Beds 130 (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

* Code: **B5*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	130			
(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 :
Sandra Nelson, HFE NE II 11/25/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 01/15/2014 (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 **11/01/1984** (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 1/16/2014 Ml

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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

CCN=245289

At the time of the standard survey completed October 24, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G) whereby corrections are required as evidenced by the attached CMS-2567. Documentation in support of the facility's request for a continuing waiver of K67 is being forwarded to the CMS RO for review and approval. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5147 5687

November 14, 2013

Mr. Dean McDevitt, Administrator
Crystal Care Center
3245 Vera Cruz Avenue North
Crystal, Minnesota 55422

RE: Project Number S5289025 Emailed documents 11/14/2013

Dear Mr. McDevitt:

On October 24, 2013, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints, 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 isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G) whereby corrections are required.

In addition, on October 25, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55108-2970

Telephone: (651) 201-3792
Fax: (651) 201-3790

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 December 3, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 3, 2013 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 January 24, 2014 (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 April 24, 2014 (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,

Kate JohnsTon
Minnesota Department of Health
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 11/13/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING ______ B. WING ______	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL CARE CENTER	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Crystal Care Center Plan of Correction is a written credible allegation of substantial compliance with the Federal and State requirements for nursing facilities and/ or skilled nursing facility participating in the Federal Medicare or State Medical Assistance programs. Please note that nothing set forth in this document is to be or should be construed to be an admission by Crystal Care Center, of validity or accuracy of any of the deficiencies cited by the Minnesota Department of Health relative to the survey, certification and enforcement effort at issue. Further, please note that any and all other communication in writing or otherwise by or on behalf of Crystal Care Center are and shall be construed to be without prejudice to the right, remedies, claims, defenses of Crystal Care Center, at law and/ or equity, all of which are not waived and all of which are reserved and retained by, for and on behalf of Crystal Care Center.	11/29/2013
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of	F 164 GD 11/20/2013	See Next pg. for start of F164	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Executive Director (X6) DATE: 11/22/2013

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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F 164	Continued From page 1 the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility staff failed to ensure 2 or 3 residents (R29, R64) were provided privacy as both residents lacked adequate personal coverage during cares to prevent unnecessary body exposure. Findings include: R29 and R64's body were left uncovered during personal care observation. On 10/22/13, at 7:45 a.m. R29 was yelling out. The surveyor entered R29's room and observed nursing assistant (NA)-A was at R29's bedside putting on a clean incontinent product. The bed blanket and sheet were bunched at the foot of the bed. R29 was lying on the bed on the right side without any covering over the body, which left R29 naked, uncovered and exposed. The resident's arms were crossed over the chest and breast area as to provide privacy from being exposed. NA-A was asked if the staff provided range of motion (ROM) to the resident's knees/lower extremities. The NA stated they were responsible for ROM, rolled R29 over onto the back and demonstrated the ROM exercises. R29 kept the arms crossed over the chest and breast area. At no time during the observation, did the NA attempt to cover R29's body from the visitor's view.	F 164	Crystal Care Center will continue to ensure that every resident will have the right to personal privacy and confidentiality of his or hers personal and clinical records and personal care. The care plans and NAR care sheets were updated reviewed and revised for R29 and R 64 to reflect the need for appropriate covering when personal cares are done. All residents have been identified to have the potential to be affected by the same deficient practice. To assure that the deficient practice will not reoccur all nursing staff will attend a mandatory in service that will be held on 11/25/13 and 11/26/13 to review procedure on providing privacy during personal care. (See attachment 1) Nurse Managers or designee will randomly audit personal care of three residents weekly times 4 weeks. Audit reports will be presented by DON to Quality Assurance committee to determine duration of Audits based on the results. Corrective action will be completed by 11/29/13	11/29/13

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F 164	Continued From page 2	F 164		

On 10/23/13, at 9:42 a.m. NA-A entered R29's room and prepared to do morning personal cares. NA-A pulled the resident's blanket and sheet down to the foot of the bed, then removed R29's top shirt. R29 crossed the arms over the chest and breast area immediately after the top was removed in order to provide privacy. The NA washed R29's face and hands and removed the hip protector garment, which left R29 body naked, uncovered and exposed to the visitor's view. R29 kept the arms crossed over the chest and breast area. The NA continued R29's personal cares until completed at 9:50 a.m. when NA-A put R29's shirt on. Then R29 uncrossed the arms across the chest and breast area. At no time during the morning personal care observation did NA-A attempt to cover R29's body from view but left the resident nude, uncovered and exposed.

On 10/23/13, at 1:15 p.m. licensed practical nurse (LPN)-H, staff development was interviewed and informed of the observation of the staff not covering the resident during cares. LPN-H stated staff are to trained to keep the resident's body covered during the personal cares, only exposing that body area during care to that area.

On 10/24/13, at 8:40 a.m. NA-A was interviewed and informed of the observation the resident was not covered, but was left naked and exposed during the care process on 10/22/13 and 10/23/13. NA-A stated he usually covers R29 with a bath blanket because she covers herself, as he used the gesture of arms crossed over the chest and breast area. NA-A stated on 10/22/13, the resident was left uncovered because he was waiting form the nurse to come into the room to do the weekly skin check. NA-A was asked to

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F 164	Continued From page 3 explain the process used during morning cares. NA-A stated "You go from one body part to the other and cover the body otherwise." On 10/24/13, at 10:10 a.m. family member (F)-K was interviewed and explained what was observed during cares and R29 moved the arms to cover the chest and breast area. F-K stated R29 had been very modest all through their married life and that R29 would not like it if her body was exposed. The 10/11/13, annual Minimum Data Set (MDS) indicated the R29's diagnoses included dementia with behavior disturbance, mood disorder, depressive/anxiety, obsessive compulsive disorder (OCD) and persistent mental disorder. R29 needed extensive assistance with activities of daily living (ADL's) which included transfers, dressing, and personal hygiene. The test done to determine R29's current mental status Brief Interview for Mental Status (BIMS) was not completed as the resident had advanced dementia and was unable to participate in the evaluation. R64 was observed during cares on 10/24/13, and the body was not covered appropriately. On 10/24/13, at 7:46 a.m. NA-B entered R64's room to do morning personal cares. The NA pulled the bed blankets and sheet down and bunched them up at the foot of the bed. The NA removed the resident's night gown and without covering any part of the resident's body, NA-B began R64's personal hygiene needs of washing the face, oral cares, changed the resident's incontinent pad and perineal care. At 8:13 a.m.	F 164		

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F 164	Continued From page 4 R64 sat at the edge and was able to participate in dressing. Throughout the morning personal cares NA-B did not attempt to cover the resident's body from the visitor's view. On 10/24/13, at 8:25 a.m. NA-B was informed of the observation that R64's body was not covered after the night gown was removed, but left her naked and exposed while doing cares. NA-B stated, "That was a mistake, I should use a blanket to cover the resident up when doing morning cares." On 10/28/13, at 1:35 p.m. F-P was interviewed via the telephone. F-P was informed of the observation during personal cares, staff pulled the blanket and sheets down towards the end of the bed which left R64's body exposed and uncovered. F-P stated, "That's not right. All his life he said his mom was a private person and it was difficult for her to have a young black male staff take care of her." F-P stated R64 would not like it if she was aware her body was exposed to staff or visitors. R64 resided in the secured dementia unit. The 10/1/13, annual MDS indicated the R64's diagnoses included advanced dementia with behaviors, depression, generalized anxiety, malaise, fatigue, atrial fibrillation and cardiac pacemaker. R64 required extensive assist with all ADLs, which include personal hygiene needs. The BIMS score was 5 which indicated severe cognitive impairment. Has short term memory problems and poor judgement skills. The 11/7/11, the care plan indicated the resident required extensive assistance in all ADL areas including personal hygiene, dressing, and oral	F 164		

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F 164	Continued From page 5 cares. The the care plan also indicated the resident had impaired thought process related to advanced dementia with poor judgement. When asked for the policy and procedure for personal care and dignity, the facility provided the Volunteer of America Nursing Home Resident's Bill of Rights dated 7/07, which indicated "Every resident has the right to be treated with consideration, respect and with full recognition of his/her dignity and individuality, including privacy in treatment and in care for his/her personal needs." The facility provided no other policy/procedures related to provision of personal care.	F 164		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the	F 225	See next pg. for start of F225	

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F 225	Continued From page 6 State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a thorough investigation was completed and to implement appropriate policies regarding timely reporting of allegations of potential abuse, neglect or mistreatment of 1 of 3 residents (R57) reviewed for abuse prohibition to the designated State agency (SA). Findings include: The facility did not ensure R57's concerns were reported immediately to the SA. During an interview with on 10/21/13, at 5:39 p.m. R57 expressed the facility was short of staff at times and they do not help when he requested assistance to the toilet. R57 stated, "Yesterday, I asked a staff to assist me to use the bathroom for about an hour while I was sitting in the wheel chair. They did not help me and later I told two of the nursing staff to assist me or I will have a crap on the floor and the nursing assistant says I could	F 225	Crystal Care Center has written policies and procedures to conduct thorough investigations regarding allegations of mistreatment, neglect, abuse and misappropriation of resident's property. The facility will ensure a thorough investigation of alleged mistreatment is completed, including timely reporting of allegations as a mandated reporter. Crystal Care Center's policy is to report to the ED or designee and SA immediately and to investigate all allegations of mistreatment, abuse, neglect, misappropriation of resident's property promptly as specified in regulation. Incident of allegation for abuse involving R57 identified in this statement of deficiency was reviewed. A Concern or Problem Resolution form was completed. Incident reported to ED and SA. Investigations were reviewed and completed. Staff and resident interviews conducted. Internal investigation completed and allegation abuse and neglect ruled out. R57 expired at the hospital 10/23/13. Crystal Care Center will identify other residents having the potential to be affected by the same deficient practice by: The ED, DON, and DSS or designees will complete review of active incidents during daily IDT meeting, conduct thorough investigations for allegations for abuse, neglect, mistreatment, and misappropriation of property, and review.	11/29/2013

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F 225	Continued From page 7 go ahead and have a crap on the floor. I spoke with the administrator today about those staff; hopefully something is done about that." Review of R57's care plan dated 7/30/13, indicated R57 "needs extensive assist of two toileting, peri-care. Is incontinent of b/b [bowel/bladder]. Uses EZ stand [mechanical lift] for transfers." The 10/4/13, annual Minimum Data Set (MDS) indicated R57 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. R57 was able to understand and understood other with no impaired vision or hearing, The MDS also indicated R57 requires extensive assist of two with bed mobility, transfers, dressing and toileting, and frequently incontinent with bowel and bladder. R57 also had diagnoses not limited to diabetes, depression, and congestive heart failure. During interview on 10/22/13, at 3:27 p.m. executive director (ED) reported that he had spoken with R57 regarding the alleged rude treatment by nursing assistants. He added he delegated the task to the social services director (SSD) who was investigating. During interview on 10/22/13, at 3:32 p.m. SSD stated, "I have not called to report the incident to SA at this time but the investigation is in place." On 10/23/13, at 9:35 a.m. SSD added, R57 did not mentioned staff names involved but she was able to determine which staff during her investigation. During interview on 10/23/13, at 1:35 p.m. the director of nursing (DON) expressed R57 had	F 225	All employees of the facility will receive education re: reporting allegations involving potential mistreatment, neglect or abuse on 11/25/13 or 11/26/13. The Vulnerable Adult Act and Resident Protection Manual, including reporting process will continue to be reviewed at orientation for new hires and reviewed on an annual basis by all staff. The DSS or designee will monitor the effectiveness of these actions, including: implementation of tracking log to track incidents requiring investigation. Incidents will be reviewed at daily IDT meeting and team will ensure incidents are thoroughly investigated according to policy and procedure and regulatory requirements. Management team will be trained by the DSS. Audits of staff to confirm knowledge of Resident protection policy and compliance will be completed by SSD or designees to ensure compliance with potential maltreatment reporting requirements/policy: weekly times 4 weeks and monthly times 2 months. (See attachment 3) Audit reports will be presented at Quality Assurance Committee by the SSD times 3 months to make certain that corrective actions is achieved and sustained. Corrective Action will be completed by 11/29/13.	11/29/2013

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F 225	Continued From page 8 numerous unsubstantiated complaints in the past and that even though they took every concern or complaint serious, but they just did not find the 10/22/13, incident warranting an immediate reporting to SA. She added "His allegations were taken seriously, but this one would not rise to reporting to SA and even now I would not report it." During interview on 10/24/13, at 2:20 p.m. DON stated, "If SSD said, none of the incident was reported to SA, I believed her because she is the one who does it." On 10/24/13, at 2:20 p.m. with housekeeper (H)-Z, stated, "I did not witness him telling the nursing assistant that he is going to crap on the floor and the nursing assistant saying back to him to go ahead but [R57] told me that." The facility's Resident/Client/Participant Protection Policy and Procedure revised 12/2012, directed on page 3, "Note: Immediate reporting pertains to long term care." In addition, on page 7, "A mandated reporter shall make an oral report to the state reporting agency immediately (or per State guidelines)."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced	F 226	Crystal Care Center has written policies and procedures that prohibit mistreatment, neglect and abuse of residents. Policies and procedures identify thorough investigations regarding allegations of mistreatment, neglect, abuse and misappropriation of resident's property as part of the investigative process. Documentation of investigations will be maintained including witness statements, from alleged perpetrator(s), victim(s), resident(s) and visitors.	11/29/2013

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F 226	Continued From page 9 by: Based on interview and document review, the facility failed to implement the written policies to immediately report to the administrator and State agency (SA) potential neglect for 1 of 3 (R57) residents reviewed for mistreatment. Findings include: The facility's Resident/Client/Participant Protection Policy and Procedure revised 12/2012, noted on page 3, "Note: Immediate reporting pertains to long term care." In addition, on page 7, "A mandated reporter shall make an oral report to the State reporting agency immediately (or per State guidelines)." During an interview with on 10/21/13, at 5:39 p.m. R57 expressed the facility was short of staff at times and they do not help when he requested assistance to the toilet. R57 stated, "Yesterday, I asked a staff to assist me to use the bathroom for about an hour while I was sitting in the wheel chair. They did not help me and later I told two of the nursing staff to assist me or I will have a crap on the floor and the nursing assistant says I could go ahead and have a crap on the floor. I spoke with the administrator today about those staff; hopefully something is done about that." Review of R57's care plan dated 7/30/13, indicated R57 "Needs extensive assist of two toileting, peri-care. Is incontinent of b/b [bowel/bladder]. Uses EZ stand [mechanical lift] for transfers." On 10/22/13, at 3:27 p.m. the executive director (ED) reported that he had spoken with R57 regarding the alleged rude treatment by nursing	F 226	The facility must have evidence that all alleged violations are immediately reported, thoroughly investigated and must prevent further potential abuse while the investigation is in process as specified in regulations. Crystal Care Center is to investigate all allegations of mistreatment, neglect, abuse, and misappropriation of resident's property promptly as well as report allegations to ED and SA immediately. The facility has written policies and procedures that include the seven abuse prohibition components including screening, training, prevention, identification, investigation, reporting and response. Incident of allegation for abuse involving R57 identified in this statement of deficiency was reviewed. A Concern or Problem Resolution form was completed. Incident reported to ED and SA. Investigations were reviewed and completed. Staff and resident interviews conducted. Internal investigation completed and allegation abuse and neglect ruled out. R57 expired at the hospital 10/23/13. Crystal Care Center will identify other residents having the potential to be affected by the same deficient practice by: The ED, DON and SSD or designee will complete review of active incidents during daily IDT meeting, conduct thorough investigations for allegations for abuse, neglect, mistreatment, and misappropriation of property, and review.	11/29/2013

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F 226	Continued From page 10 assistants. He added, he delegated the task to the social services director (SSD) who was investigating. On 10/22/13, at 3:32 p.m. SSD stated, "I have not call to report the incident to SA at this time but the investigation is in place." On 10/23/13, at 9:35 a.m. SSD added, R57 did not mentioned staff names involved but she was able to determine which staff during her investigation. On 10/23/13, at 1:35 p.m. the director of nursing (DON) expressed R57 had numerous unsubstantiated complaints in the past and that even though they took every concern or complaint serious, but they just did not find the 10/22/13, incident warranting an immediate reporting to SA. She added "His allegations were taken seriously, but this one would not rise to reporting to SA and even now I would not report it."	F 226	All employees of the facility will receive education re: reporting allegations involving potential mistreatment, neglect or abuse on 11/25/13 or 11/26/13. The Vulnerable Adult Act and Resident Protection Manual, including reporting process will continue to be reviewed at orientation for new hires and reviewed on an annual basis by all staff. Staff designated to report to SA will receive additional training by DSS. The DSS or designee will monitor the effectiveness of these actions, including: audits of the tracking log of incidents requiring investigation will be completed by SSD or designees to ensure compliance with potential maltreatment reporting requirements and policy: weekly times 4 weeks and monthly times 2 months. Audit reports will be presented to QA Committee by the SSD times 3 months to make certain that corrective actions is achieved and sustained. Corrective Action will be completed by 11/29/13.	11/29/2013
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329	See next pg. for start of F329	

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	245289	A. BUILDING ______ B. WING ______	10/25/2013

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F 329	Continued From page 11 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 ensure adequate indication for use had been identified prior to the start of an antianxiety medication for 1 of 5 residents (R138) in the sample reviewed for unnecessary medications. Findings include: The quarterly Minimum Data Set (MDS) dated 8/30/13, indicated R138 had a Brief Interview of Mental Status (BIMS) score of seven (severely impaired cognitive status), had delusions, rejected care one to three days and required physical help of one for bathing. The diagnoses noted included anxiety and depression. The Activities of Daily Living (ADL) care plan dated 7/19/13, noted R138 refused to bathe at times and directed if refusing bath, attempt to get an agreeable time for the bath and re-approach to get cooperation. The cognition care plan dated 9/12/13, directed to keep routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion.	F 329	Crystal Care Center will continue to ensure that each resident's drug regimen must be free from unnecessary drugs. Ativan given prior to bath for R138 was discontinued. Care plan and NAR care sheet were updated to reflect alternative non pharmaceutical interventions. Also nurses to document resident behavior prior to/ during and following bath every Tuesday on the TAR and PCC. NAR will document behavior and bathing Q shift on Point of Care and report behaviors to the nurse. One other resident was identified having the potential to be affected by the same deficient practice. Care plan and NAR care sheet were updated to reflect alternative non pharmaceutical interventions. Nurses to document resident behavior prior to/ during and following baths every Tuesday and Saturday on the TAR and PCC. NAR will document behavior and bathing Q shift on Point of Care and report behaviors to the nurse. To assure that the deficient practice will not reoccur all nursing staff will attend a mandatory in service on 11/25/13 and 11/26/13. Necessity of behavior documentation with non pharmacological interventions will be discussed (See attachment 4). IDT will review weekly any residents with new psychoactive drug orders. Pharmacist will review each resident monthly for unnecessary drug use per	11/29/13

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F 329	Continued From page 12 The Behavior Summary Reports were reviewed. For the weeks ending 7/7/13, 7/14/13, 8/11/13, 8/25/13 and 9/1/13, one episode of rejection of care was documented for each week. For the weeks ending 7/21/13, 7/28/13, 8/3/13, 8/18/13 and 9/8/13, no episodes of rejection of care were documented. The behavior symptoms documentation provided indicated that on Tuesdays (bath days) no behavior occurred on 7/9/13, 7/16/13, 7/23/13, 7/30/13, 8/6/13, 9/10/13, 9/24/13, 10/15/13 yelling/screaming occurred on 8/13/13, rejection of care occurred 8/20/13, 9/3/13, 9/17/13, 10/1/13, abusive language occurred on 8/27/13, 10/22/13 and threatening behavior occurred on 10/8/13. Review of the Progress Notes for 8/1/13 through 9/9/13, did not indicate R138 was resistive with bathing. The 1st Floor Weekly IDT [interdisciplinary team] Meeting summary dated 9/9/13, included issues of refuses to ambulate and refuses to stand and indicated "try PRN [as needed] Ativan B/4 [before] bath." A physician's order dated 9/9/13, directed Ativan 0.25 milligrams (mg) in the morning every Tuesday 1/2 hour prior to bath for anxiety. A Progress Note dated 9/9/13, indicated R138 was started on Paxil (an antidepressant medication) in August 2013 for mild depression. A Progress Note dated 9/10/13, indicated R138 did not have anxiety before the bath and requested to have the bath later in the day which	F 329	per Drug Regimen Review. Any resident on a psychoactive drug will be reviewed during Quality Of Life Rounds. DON will report minutes of Quality Of Life Rounds and Gradual Dose Reduction to QA committee. HIMD will report results on Prescription Count Totals to QA committee. Corrective Action will completed by 11/29/13	11/29/2013

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F 329	Continued From page 13	F 329		

was done.

A Progress Note dated 10/8/13, indicated R138 had a bath in the afternoon and was cooperative with it.

When interviewed on 10/23/13, at 2:27 p.m. R138 and family member (F)-L reported R138 did not like showers because the water was too hot or too cold. R138 reported he complained and now gets baths instead of showers which are more comfortable. F-L agreed bathing was better now that R138 received baths instead of showers.

When interviewed on 10/24/13, at 7:45 a.m. nursing assistant (NA)-D reported R138 had refused a shower about three months ago after having an argument with a family member.

On 10/24/13, at 8:01 a.m. NA-E reported R138 "Gives them trouble sometimes because he likes things done his way. We know him so it's okay."

When interviewed on 10/24/13, at 8:06 a.m. licensed practical nurse (LPN)-I stated R138 refused a shower especially with new people and needed reassurance from staff the new employees know what they are doing.

Registered nurse (RN)-C was interviewed on 10/24/13, at 9:06 a.m. and stated would have R138's wife talk to him or have one of his favorite girls bath him and if he refused would keep trying until he accepted a bath. RN-C verified no information was available regarding interventions used prior to starting medications.

The director of nursing was interviewed on 10/24/13, at 10:00 a.m. and stated PRN Ativan

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F 329	Continued From page 14 was not used instead of scheduled Ativan for R138 because the nurses do not give PRNs. The facility Psychoactive Medication Use and Gradual Dose Reduction Policy dated 2010, directed "a resident will not receive unnecessary medications including psychoactive medications, unless non-pharmacological interventions have failed to sufficiently modify a resident's target behavioral, mood, or sleep disturbance." The medical record, lacked evidence of the effectiveness of any non-pharmacological interventions used to assist with bathing prior to starting scheduled Ativan.	F 329		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	Crystal Care Center will ensure that drugs and biologicals used in the facility will be labeled in accordance with currently accepted professional principals, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable. The medications for the residents affected by the deficient practice were removed from the med carts. All facility med carts were audited to identify other residents having the potential to be affected by the same deficient practice. No other residents were identified.	11/29/2013

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F 431	Continued From page 15 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that medications were stored and labeled properly for 8 of 8 residents (R63, R110, R9, R42, R106, R102, R86, R100) reviewed for medication storage. Findings include: Eight residents received insulin injections or eye drops which were undated when opened. TCU: During the tour of medication storage area in the Transitional Care Unit (TCU) on 10/21/13, at 12:13 p.m. R63's open, undated polymyxin B-Trimetho (used to treat bacterial eye infections) eye drop bottle was stored in the medication cart. During the interview with registered nurse (RN)-Z verified the eye drop bottle needed to be dated when opened and would inform the director of nursing (DON) of opened, undated medications stored in the medication cart. The October 2013	F 431	To assure that the deficient practice will not reoccur all nurses will attend a mandatory in service that will be held on 11/25/13 and 11/26/13.Unit Reference books were reviewed, with focus on the Recommended Minimum Medication Storage Parameters. All Nurses will use Red Fine Sharpie pens kept in each Med Cart, to document open date and expiration date on all appropriate medications. Night Shift Nurse Duty procedure introduced (See attachment 5). Nurse Managers or Designees will audit med carts every Monday times 4 weeks and will report audit results to QA Committee to determine duration of Audits based on the results. Med carts audit to be done quarterly by consulting pharmacy nurse. (See attachment 6) Corrective Action will be completed by 11/29/13	11/29/2013

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F 431	Continued From page 16 medication administration record (MAR) indicated R63 received the eye drops. North unit first floor: During the tour of medication storage area located on first floor, North unit on 10/21/13, at 12:30 p.m. following opened, undated medications were observed in the medication cart: R110's had an opened and undated latanoprost (used for controlling the progression of glaucoma) eye drop bottle. R9's had five opened, undated Lantus and Aspart insulin pens (used to treat diabetes). R42's had an opened, undated Lantus and Novolog (Insulin) flex pens. R106's had an opened, undated Lantus Solostar insulin pen. During the interview licensed practical nurse (LPN)-Z verified the medications needed to be dated when opened and stated would inform the DON. 3 North: During the medication storage area tour on 10/21/13, at 6:07 p.m. in 3 North unit, R102's Novolog insulin flex pen had expiration date of 10/16/13, LPN-Z indicated the insulin pen was expired and should not have been administered an hour ago to resident. LPN-Z added the expired medication would be ordered from the pharmacy to replace it. 2 North: During the medication storage area tour on 10/22/13, at 11:30 a.m. on 2 North unit, it was observed R86's dorzolamide (an anti-glaucoma agent) and Latanoprost (used for controlling the	F 431		

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progression of glaucoma) eye drop bottles had open date of 8/21/13.

LPN-X stated, "Way past the expiration date. I am going to reorder new medications and will destroy these medications."

The Xalatan Drug Factsheet dated 1996-2013, directed eye drops must be used within six weeks after opening the container. Additionally, the dorzolamide Consumer Medicine Information sheet dated April 2013, directed "Write the date on the bottle when you open the eye drops and throw out any remaining solution after four weeks."

2 South:
During the medication storage area tour on 10/22/13, at 11:45 a.m. on 2 South unit, it was observed R100's two Alphagan P 0.1% eye drop (used to treat glaucoma) bottles one was undated and another had open date of 7/24/13.

LPN-W verified and stated, "I will go on pharmacy online to see the instruction and go from there."

The Medication Administration Record (MAR) for October 2013 indicated R9, R42, R63, R86, R100, R102, R106, and R110 had been receiving the undated or expired medications.

On 10/23/13, at 1:19 p.m. LPN-V stated her expectation was staff to date all multiple dose medication bottles when they opened them. LPN-V further stated when medications are received from the pharmacy, they usually came with a sticker on which staff had to write the date when a medication bottle was opened.

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F 431	Continued From page 18 On 10/23/13, at 1:23 p.m. DON stated, "I was made aware of the concerns regarding undated open eye drops and insulin pens. I know we need improvement on this." DON added we have been working on that issue with the staff. During an interview with the facility's consultant pharmacist (CP) on 10/24/13, at 12:00 p.m., CP stated his expectation was facility staff to date each medication bottle when opened. He further indicated, "It should have been done and they just did not do it." The facility 5.3 Storage and Expiration of Medications, Biological, Syringes and Needles policy and procedure revised 1/1/13, directed "4.1 Have an Expiration Date on the label, 5 Once ant medication or biological package is opened, Facility should follow manufacture/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. 5.1 Facility may record the calculated expiration date based on the date opened on the medication container."	F 431		11/29/2013
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441	See next pg. for Start of F441	

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F 441	Continued From page 19 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate glove changes and aseptic technique was used during catheter care to prevent the spread of infection for 1 of 2 residents (R63) observed for catheter care. Findings include:	F 441	Crystal Care Center will continue to maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. R63's Care plan and NAR care sheet reviewed and revised to reflect aseptic techniques for catheter care. One other resident was identified to have the potential to be affected by the same deficient practice. (Has indwelling Foley catheter). Care plan and NAR care sheet reviewed and revised to reflect aseptic techniques for catheter care. To assure that the deficient practice will not reoccur all nursing staff will attend a mandatory in service that will be held on 11/25/13 and 11/26/13. Policies and procedure for Catheter Care "Indwelling Catheter" and Glove Technique will be reviewed. The Infection Control nurse will observe/audit Glove Technique and Catheter Care on two residents Q week times 4 weeks. (See attachment 7) Infection Control Nurse will report results to QA Committee. QA Committee will determine duration of audits based on the results of the audits. Corrective Action will be completed by 11/29/13	11/29/2013

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Continued From page 20

R63's admission Minimum Data Set (MDS) dated 9/11/13, revealed diagnoses of benign prostatic hyperplasia (BPH) and obstructive uropathy. The MDS indicated R63 had an indwelling Foley catheter, was frequently incontinent of bowel and required extensive assist of two for toileting and personal hygiene.

The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 9/18/13, indicated the overall objective of care planning for this problem was to maintain current level of functioning and minimize risks.

The elimination care plan dated 9/18/13, indicated R63 had an indwelling catheter, had only one kidney and was frequently incontinent of bowel. The care plan included a goal of will remain free of signs and symptoms of a urinary tract infection (UTI). The care plan directed staff to provide pericare every morning/evening and with each incontinent episode.

On 10/24/13, at 8:09 a.m. nursing assistant (NA)-D was observed providing morning cares. NA-D applied gloves washed R63's face, underarms and peri-area. NA-D then assisted R63 to roll on the side, cleansed bowel movement (BM) from the buttocks area and applied lotion to both buttocks. With the same gloves and without washing his hands, NA-D put the catheter bag through the leg of R63's pants and emptied the catheter bag, touching the end of the tubing.

When interviewed on 10/24/13, at 8:33 a.m. NA-D verified he had not changed his gloves or washed his hands while providing catheter care

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F 441	Continued From page 21 for R63. When interviewed on 10/24/13, at 10:20 a.m. the licensed practical nurse (LPN)-H who served as the facility infection control nurse, stated staff are expected to change their gloves and wash their hands after cleaning BM and before providing catheter care. When interviewed on 10/24/13, at 2:40 p.m. the director of nursing (DON) verified that gloves should be removed and hands washed after cleaning BM and before draining the catheter bag. The facility Glove Technique (Non-Sterile) policy and procedure dated 2013, directed to "Change gloves between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms." The facility Catheter Care (Indwelling Catheter) policy and procedure dated 2006, directed "NOTE: DO NOT CONTAMINATE AREA WITH FECES. IF RESIDENT HAS HAD AN INVOLUNTARY BOWEL MOVEMENT, CLEAN THIS AREA FIRST. WASH YOUR HANDS AND OBTAIN CLEAN EQUIPMENT FOR CATHETER CARE."	F 441		

Privacy/ Dignity During Cares Observation Audit

#2

NAR	DATE	TIME	Resident initials	Observed by
DOOR CLOSED		YES	NO	EDUCATION PROVIDED
PRIVACY CURTAIN CLOSED		YES	NO	EDUCATION PROVIDED
PRIVACY PROVIDED				
TORSO		YES	NO	EDUCATION PROVIDED
PERI CARE		YES	NO	EDUCATION PROVIDED
DRESSING		YES	NO	EDUCATION PROVIDED
TOILETING		YES	NO	EDUCATION PROVIDED
DIGNITY		YES	NO	EDUCATION PROVIDED
		YES	NO	EDUCATION PROVIDED

NAR	DATE	TIME	Resident initials	Observed by
DOOR CLOSED		YES	NO	EDUCATION PROVIDED
PRIVACY CURTAIN CLOSED		YES	NO	EDUCATION PROVIDED
PRIVACY PROVIDED				
TORSO		YES	NO	EDUCATION PROVIDED
PERI CARE		YES	NO	EDUCATION PROVIDED
DRESSING		YES	NO	EDUCATION PROVIDED
TOILETING		YES	NO	EDUCATION PROVIDED
DIGNITY		YES	NO	EDUCATION PROVIDED
		YES	NO	EDUCATION PROVIDED

NAR	DATE	TIME	Resident initials	Observed by
DOOR CLOSED		YES	NO	EDUCATION PROVIDED
PRIVACY CURTAIN CLOSED		YES	NO	EDUCATION PROVIDED
PRIVACY PROVIDED				
TORSO		YES	NO	EDUCATION PROVIDED
PERI CARE		YES	NO	EDUCATION PROVIDED
DRESSING		YES	NO	EDUCATION PROVIDED
TOILETING		YES	NO	EDUCATION PROVIDED
DIGNITY		YES	NO	EDUCATION PROVIDED
		YES	NO	EDUCATION PROVIDED

CARES SKILL SHEET

#1

NAR________________	DATE	TIME	RESIDENT INITIALS	OBSERVED BY		YES	NO
Remove or fold back top linen, keeping resident covered with bath blanket or top sheet.							
Remove only clothing necessary to perform cares while avoiding overexposure.							
When assisting resident, move body parts gently and naturally.							
Uncover only one part of the body at a time.							
Maintain personal privacy and warmth.							
Remove gloves and wash hands.							
Assist resident into clean gown or clothing of choice.							

Attachment 3

Resident Protection Staff Audit

Interview a staff person. Follow-up on Incorrect answers and document	Staff/Date	Staff/Date	Staff/Date	Staff/Date	Staff/Date	Staff/Date
Staff is wearing name tag?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
What is reported to supervisor/Executive Director?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
When do you report skin tears or bruises, abuse n injury of unknown origin?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
What do you do when a resident states someone	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Who do you report potential abuse or neglect or ir unknown origin to In your facility?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Are you comfortable reporting abuse or neglect internally?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
If you were not comfortable reporting abuse or neglect internally – who would you report suspected abuse or neglect to?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
What would you do if a resident states that a staff member laughed at or made fun of them?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
How would you intervene or redirect a resident Who was acting out towards another resident?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
What resources are available to you to prevent Staff burnout? What would you do if you were Feeling stressed?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No

Interview a staff person. Follow-up on Incorrect answers and document	Staff/Date	Staff/Date	Staff/Date	Staff/Date	Staff/Date	Staff/Date
Staff are wearing a name tag?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
What is reported to supervisor/Executive Director?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
When do you report skin tears or bruises, abuse n injury of unknown origin?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
What do you do when a resident states someone	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Who do you report potential abuse or neglect to or injury of unknown origin to In your facility?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Are you comfortable reporting abuse or neglect internally?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
If you were not comfortable reporting abuse or neglect Internally – who would you report suspected abuse or neglect to?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
What would you do if you found a bruise on a Resident that was several days old?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
How would you intervene or redirect a resident Who was acting out towards another resident?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
What resources are available to you to prevent Staff burnout? What would you do if you were Feeling stressed?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No

Note Actions taken for any incorrect answers, example-training/education________________________

____

____

Evaluator: ________________________ Date ____________

#4

Resources for Non-Pharmacological Interventions

"Non-pharmacological interventions" refers to approaches to care that do not involve medications, generally directed towards stabilizing or improving a resident's mental, physical or psychosocial well-being.

Examples of non-pharmacological interventions may include:

- Increasing the amount of resident exercise, intake of liquids and dietary fiber in conjunction with an individualized bowel regimen to prevent or reduce constipation and the use of medications (e.g. laxatives and stool softeners

- Identifying, addressing, and eliminating or reducing underlying causes of distressed behavior such as boredom and pain

- Using sleep hygiene techniques and individualized sleep routines;

- Accommodating the resident's behavior and needs by supporting and encouraging activities reminiscent of lifelong work or activity patterns, such as providing early morning activity for a farmer used to awakening early;

- Individualizing toileting schedules to prevent incontinence and avoid the use of incontinence medications that may have significant adverse consequences (e.g., anticholinergic effects)

- Developing interventions that are specific to resident's interests, abilities, strengths and needs, such as simplifying or segmenting tasks for a resident who has trouble following complex directions;

- Using massage, hot/warm or cold compresses to address a resident's pain or discomfort

- Enhancing the taste and presentation of food.

Behavior Interventions Resource

When you find ways to work well with specific residents, report them so they can be added to the care plan!

Always Do This

- **Identify yourself and approach calmly**. Call resident by preferred name. Keep arm's length away until you get their attention. Don't raise your voice but speak slowly and clearly.
- **Be friendly**. Don't try to boss or talk down to the resident.
- **Establish eye contact**. Don't confront or block resident's view of surroundings.
- **Explain what you want to do**. Use short simple phrases or sentences.
- **Break down tasks into simple steps**. Use gestures. Demonstrate.

- **Give simple choices**. Let the resident have control.
- **Accept the behavior and work with it** - if it isn't harmful, let it be and try to find ways to work with it.
- **Leave and re-approach** – In 5 minutes or later.
- **Ask another care giver to attempt care later.**

Try These Interventions

- **Discuss old memories** – Family, job, hobbies, events
- **Offer Touch** – Handshake, hand-holding, if appropriate
- **Engage him in an activity** – He may simply be bored and need something to do. Provide structure and engage the person in a pleasant activity.

Assess For These Problems and Intervene As Appropriate

- **Pain** – Check for cause, tell nurse, don't force while in pain
- **Assess for acute illness/delirium** – Fever, labs (ua, bs, lytes, wbcs, etc.), VS
- **Reposition** – Make more comfortable
- **Initiate Behavior Symptom Assessment/Plan of Care**
- **Need for toileting/change briefs** – Provide toileting, change briefs
- **Thirst** – Offer something to drink
- **Hunger** – Offer a snack
- **Room temperature** – Adjust for comfort
- **Clothing uncomfortable** – Change if needed
- **Body temperature** – Check for fever, possible infection, tell nurse
- **Voiding** – check for UTI – Talk with nurse if you think it might be the case
- **Constipation/fecal impaction** – Check last BM, tell nurse
- **Dentures/teeth** – Do oral care, report problems to nurse
- **Hearing aides** – Check need for cleaning, battery change
- **Bored, restless** – Offer something to do- activity boxes, talk a walk, etc.
- **Over-stimulated** – Take resident to a quieter, safe environment
- **Medication actions, side effect, or interactions may be the cause** – Consult a pharmacist - behavioral symptoms may be resulting from medication(s).

Caregiver Coping

- Help each other – when working with residents you know you find challenging.
- Look for reasons – for each behavior.
- Take another caregiver with you – together, you may find easier ways to approach and intervene
- Stay calm – be understanding, patient and flexible.
- Respond to the emotion – of the person who needs helps, not the behavior; don't argue – or try to convince.
- Acknowledge requests – respond to them.
- Try more than one solution – every intervention doesn't work every time
- Find other outlets for the resident's stress – to relieve tension that may be causing the behavior

- Try not to take behaviors personally – Talk to others about your feelings.

#5

NIGHT SHIFT NURSE DUTIES

1. Medication carts will be cleaned each Sunday NIGHT.

   Take out all medication and wipe down drawer.

   Check for" Date Open" on all medications that require this.
   All should have the date it was open on it, Written in RED sharpie.
   If something does not have date written on it you must pull from med
   Cart and reorder that from pharmacy.

   All eye drops/ointments are to be in labeled bag from pharmacy. Each bag will have A "Discard Date" sticker placed on it when opened with the date it needs to Be discarded written on sticker in RED sharpie.

   Insulin Pens are to be marked with" Date Open" and "Discared Date" This Is to be done in RED sharpie.

   Blood sugar machine are to be in separate bag with a bottle of test strips in Each bag. Each tube of strips must have "Date Open" maked on it in RED Sharpie.

   Purple Books at nurses' stations have guides for date references. If something is not listed use Nursing drug book.

2. Medication that is not longer in use will be disposed of per Crystal Care Center's policy
3. Refrigerators at Nurse's station/Med rooms will be stocked with Nutritional Supplements each night ready for the next day.
4. Nurses station will be clutter free, all charts put in their appropriate places.
5. Medication Rooms will be clean and well organized, things off the counter and put away.
6. Medication carts will be restocked each night with glasses, med cups, and spoons, ready for use.
7. Check 3 day Bowel and Bladder for completion when being used. If incomplete restart for another 3 days.
8. Lab sheets out and ready for lab draws each morning.

9. **Paper work ready for appointments, dialyses, etc. Each envelope should have copy of face sheet, copy of medication sheets and a Completed Clinical referral sheet.**

10. **Check that residents with o2 and or Bi Pap machines etc, that machines are on, and working. Portable o2 tanks are full and ready for morning use.**

11. **T.V. and lights are off when resident are asleep.**

12. **You will make first and last rounds with NAR's. This is asure that all resident are accounted for.**

13. **O2 tubing will be changed weekly. This has to be dated and initial; both portable and stationary tanks. O2 supplies are in the O2 room on 3rd floor. Char on TAR's.**

14. **Nebulizer setups are to be changed every 3 weeks. This has to be dated and initial . Chart on TAR's**

15. **Make BM list for day shift per CCC procedure. Give list to day nurse during morning report. See BOWEL MANAGEMENT PROGRAM in purple book.**

16. **Make sure Ted Hose are clean and ready for A.M. Cares. Night shift to put on Ted Hose if residents are ready to get up prior to 7:00 A.M.**

17. **Monthly Charting due on day its assisgned. Day shift to open and do shift 1, Afternoon shift will do shift 2 and night shift will do shift 3. When all three are completed the night Nurse will lock the assessment once they have completed their section.**

18. **Temperatures are to be recorded on each refrigerator in each nurses station, every night, by the night shift. A form is provide on each refrigerator.**

Random audit will be done for compliance of assigned duties.
Questions please direct them to Nurse Managers or to Director of Nursing.

#6

MEDICATION CART AUDIT

DATE_____________

NORTH CART	YES	NO	ADDITIONAL NOTES
All medications and biologicals labeled with open date and			
expiration date?			
If NO were they removed and replacement ordered?			
Are any expired medications or biologicals found?			
If YES were they removed and replacement ordered?			
Are Red sharpie pens present in the cart?			

SOUTH CART	YES	NO	ADDITIONAL NOTES
All medications and biologicals labeled with open date and			
expiration date?			
If NO were they removed and replacement ordered?			
Are any expired medications or biologicals found?			
If YES were they removed and replacement ordered?			
Are Red sharpie pens present in the cart?			

11/13jk

Glove Use and Proper Catheter Care Audit

#7

Date__________	Staff________________	time_____		
TASK		**YES**	**NO**	**Education provided/comments**
Handwashing				
	correct procedure			
	instant sanitizer			
Catheter Care				
	Privacy/dignity			
	Peri-care			
	Catheter care			
	Catheter bag emptying process			
Glove use				
	puts on at correct times			
	removes after contaminated			
	proper hand sanitizing			

OBSERVATION BY ______________________________

ADDITIONAL OBSERVATIONS OR EDUCATION PROVIDED:

Date__________	Staff________________	time_____		
TASK		**YES**	**NO**	**Education provided/comments**
Handwashing				
	correct procedure			
	instant sanitizer			
Catheter Care				
	Privacy/dignity			
	Peri-care			
	Catheter care			
	Catheter bag emptying process			
Glove use				
	puts on at correct times			
	removes after contaminated			
	proper hand sanitizing			

OBSERVATION BY ______________________________

ADDITIONAL OBSERVATIONS OR EDUCATION PROVIDED:

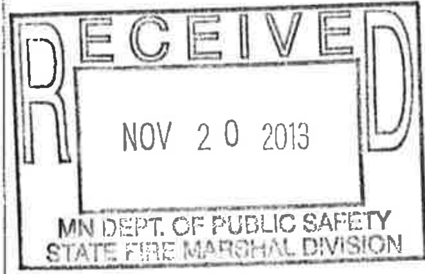
F5289023

PRINTED: 11/13/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING 01 - MAIN BUILDING 01 B. WING ____	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL CARE CENTER	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

(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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on October 10, 2013. At the time of this survey, Crystal Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	POC ok w/AW for K67 PS 11-21-13  RECEIVED NOV 20 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 12-3-13

EXIT: 10-25-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	11/20/2013

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL CARE CENTER	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

(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	Continued From page 1 Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 3-story building was constructed in 1971 and was determined to be of Type II (222) construction. It has a full basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 130 beds and had a census of 118 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067	K 067 An annual/continuing waiver is being requested for K 067. Waiver will be sent to Patrick Sheehan, Fire Safety Supervisor, Minnesota State Fire Marshal for his review and approval.	AW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	10/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL CARE CENTER	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

(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 067	Continued From page 2 This STANDARD is not met as evidenced by: Based on observations and interviews, it was observed that the facility's general ventilating and air conditioning system (HVAC) is not installed in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11. A noncompliant HVAC system could affect all residents, visitors, and staff. Findings include: On facility tour between 9:00 AM and 1:00 PM on 10/25/13, observation revealed that the ventilation system has supply ducts serving the resident corridors without return ducts in the corridors on each of the 3 floors. It appears that the only return is through the continuous operation of the resident room bathroom fans. This deficient practice was verified by the Maintenance Supervisor at the time of the inspection.	K 067		