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:	WNSK	
Faci	lity ID: 00407	7

	IAKI I -	TO BE COMIT		IIIE SIA	IE SURVET AGENCI		racility ID. 00407
MEDICARE/MEDICAID PROVIDI (L1) 245395 2.STATE VENDOR OR MEDICAID N		3. NAME AND AI (L3) CROSSRO (L4) 965 MCMII	ADS CARE CH	ENTER		4. TYPE OF ACTION	ON: <u>7 (</u> L8) 2. Recertification 4. CHOW
(L2) 146319500		(L5) WORTHING			(L6) 56187	3. Termination 5. Validation	6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEO	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey Afte	9. Other er Complaint
6. DATE OF SURVEY 09/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	6/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR END.	ING DATE: (L35)
11LTC PERIOD OF CERTIFICATION	N	10.THE FACILITY	Y IS CERTIFIED	AS:			
From (a):		X A. In Complia	ance With		And/Or Approved Waivers Of	The Following Requiren	nents:
To (b):			equirements be Based On:		2. Technical Personnel 3. 24 Hour RN		
12.Total Facility Beds	50 (L18)	•	acceptable POC				om Size
13.Total Certified Beds	50 (L17)		mpliance with Properties and/or Appli		: * Code: A	(L12)	
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS		
18 SNF 18/19 SNF 50	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date:			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Gary Nederhoff	Unit Supervis	sor 1	10/01/2015	(L19)	Ka <u>mala Fiske-Downing,</u> I	Enforcement Speci	ialist 10/01/2015 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONA	L OFFICE OR SINGLE S	STATE AGENCY	
DETERMINATION OF ELIGIBIL 1. Facility is Eligible to F 2. Facility is not Eligible	articipate		MPLIANCE WITH	H CIVIL	21. 1. Statement of Fina2. Ownership/Contr3. Both of the Above	ol Interest Disclosure Stm	
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION		(L30)
OF PARTICIPATION 01/01/1987	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00 01-Merger, Closure		NTARY Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-Fail to	Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-110010	der Status Change
(L27)	B. Rescind So	uspension Date:	(L44) (L45)			00-Active	•
28. TERMINATION DATE:	29). INTERMEDIARY	/CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVAI	L DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245395

October 1, 2015

Ms. Barbara Atchison, Administrator Crossroads Care Center 965 McMillan Street Worthington, Minnesota 56187

Dear Ms. Atchison:

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 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske. Downing

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

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



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered October 1, 2015

Ms. Barbara Atchison, Administrator Crossroads Care Center 965 McMillan Street Worthington, Minnesota 56187

RE: Project Number S5442026

Dear Ms. Atchison:

On August 28, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 13, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On September 26, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 14, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 13, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 22, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 13, 2015, effective September 22, 2015 and therefore remedies outlined in our letter to you dated August 28, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Riske. Downing

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

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

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245395	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/26/2015
Name	e of Facility		Street Address, City, State, Zip Code	
CF	ROSSROADS CARE CENTER		965 MCMILLAN STREET	
-			WORTHINGTON MN 56187	

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

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix Reg. # LSC	F0166 483.10(f)(2)		Correction Completed 09/22/2015	ID Prefix Reg. # LSC	F0225 483.13(c)(1)(ii)-(Correction Completed 09/22/2015		ID Prefix Reg. # LSC	F0226 483.13(c)		Correction Completed 09/22/2015
ID Prefix Reg. # LSC	F0329 483.25(I)		Correction Completed 09/22/2015	ID Prefix Reg. # LSC	F0356 483.30(e)		Correction Completed 08/17/2015		ID Prefix Reg. #			Correction Completed 09/22/2015
ID Prefix Reg. # LSC	F0428 483.60(c)		Correction Completed 09/09/2015	ID Prefix Reg. # LSC	F0441 483.65		Correction Completed 09/22/2015		ID Prefix Reg. # LSC	F0492 483.75(b)		Correction Completed 09/14/2015
ID Prefix Reg. # LSC				Reg. #			Correction Completed					
Reg. #				ID Prefix Reg. # LSC								
	_											
Reviewed E		Reviewed	-	Date:	Signature	e of Sur	•	01/0			Date:	7/2015
State Agen	-	GPN/kf		10/01/20		o of Cum		0160				5/2015
CMS RO	Зу	Reviewed	Бу	Date:	Signature	e oi our	veyor:				Date:	
Followup t	o Survey Cor 8/13/	npleted on 2015	1:							Summary of the Facility?	YES	NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245395	(Y2) Multiple Con A. Building B. Wing	IN BUILDING 01	(Y3) Date of Revisit 9/14/2015
Name of Facility		Street Address, City, State, Zip Code	
CROSSROADS CARE CENTER		965 MCMILLAN STREET	
		WORTHINGTON MN 56197	

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

(Y4) Item		(Y5) Date	(Y4) Item		(Y5) Date	(Y4)	Item	(Y5)	Date
		Correction Completed			Correction Completed				Correction Completed
ID Prefix			ID Prefix				ID Prefix		
•	NFPA 101			NFPA 101			Reg. #		
LSC	K0029		LSC	K0076			LSC _		
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix			ID Prefix				ID Prefix		
Reg. #			Reg. #				Reg. #		
									
		Correction			Correction				Correction
ID Dueffy		Completed	ID Duefin		Completed		ID Duefis		Completed
Reg. # LSC			Reg. # LSC				Reg. # LSC		
							_		
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix		Completed
Reg. #			Reg. #				D "		
LSC			LSC				LSC _		
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix			ID Prefix				ID Prefix		
Reg. #			Reg. #				Reg. #		
LSC			LSC				LSC _		
Reviewed I	By Re	viewed By	Date:	Signature	of Surveyor:			Date:	
State Agen	cy GS	/kfd	10/01/201	15		3548	32		09/14/2015
Reviewed I	Зу Re	viewed By	Date:	Signature	of Surveyor:			Date:	
Followup t	o Survey Comple			Check for any	Uncorrected Def	icienci	ies. Was a S		
	8/11/20	10	1			•	. ,	ie racility? YES	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: WNSR

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

	PART	I - TO BE COM	PLETED BY T	THE STAT	E SURVEY AG	ENCY		Facility ID: 00407	
1. MEDICARE/MEDICAID PROVIDER N (L1) 245395 2.STATE VENDOR OR MEDICAID NO. (L2) 146319500	0.	3. NAME AND ADDRESS OF FACILITY (L3) CROSSROADS CARE CENTER (L4) 965 MCMILLAN STREET (L5) WORTHINGTON, MN			(L6) 56187		4. TYPE OF ACTIO 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF OWN (L9)		7. PROVIDER/SUI	05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey After	9. Other r Complaint	
6. DATE OF SURVEY 08/13/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDI	NG DATE: (L35)	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	50 (L18) 50 (L17)	X B. Not in Com	equirements	n	2. Tech 3. 24 H 4. 7-Da 5. Life	nical Personnel	E Following Requirements 6. Scope of Scope	ervices Limit irector om Size	
14. LTC CERTIFIED BED BREAKDOWN		I			15. FACILITY ME	EETS			
18 SNF 18/19 SNF 50	19 SNF	ICF	IID		1861 (e) (1) or 1	1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):						
17. SURVEYOR SIGNATURE		Date :				VEY AGENCY API		Date:	
Jares Magdalene, HF	E NEII		09/14/2015	(L19)		Enforcement S	Specialist	09/30/2015	(L20)
	PART II - TO	BE COMPLETE	D BY HCFA R	EGIONAI	OFFICE OR S	SINGLE STAT	E AGENCY		
DETERMINATION OF ELIGIBILITY			IPLIANCE WITH C	CIVIL	2. C		ial Solvency (HCFA-2572) nterest Disclosure Stmt (H		
2. Facility is not Engine	(L21)								
22. ORIGINAL DATE OF PARTICIPATION 01/01/1987 (L24)	23. LTC AGREEMI BEGINNING (L41)		24. LTC AGREEMI ENDING DAT (L25)		26. TERMINAT VOLUNTARY 01-Merger, Closur 02-Dissatisfaction	00	05-Fail to	(L30) JNTARY o Meet Health/Safety o Meet Agreement	
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVE A. Suspension of B. Rescind Sus	of Admissions:	(L44)		03-Risk of Involur 04-Other Reason f	•	OTHER 07-Provi 00-Activ	der Status Change	
			(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS				
		03001							
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	(L32)	. DETERMINATION (OF APPROVAL DA	(L33)	DETERMINA	TION APPRO	VAL		
					1				



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered August 28, 2015

Ms. Barbara Atchison, Administrator Crossroads Care Center 965 McMillan Street Worthington, Minnesota 56187

RE: Project Number S5395025

Dear Ms. Atchison:

On August 13, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900 gloria.derfus@state.mn.us Telephone: (651) 201-3792

Fax: (651) 215-9697

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 September 22, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

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

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

Crossroads Care Center August 28, 2015 Page 4

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 13, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

Crossroads Care Center August 28, 2015 Page 5

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 13, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc_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. Gary Schroeder, Supervisor Health Care Fire Inspections State Fire Marshal Division pat.sheehan@state.mn.us Telephone: (651) 201-7205

Fax: (651) 215-0525

Crossroads Care Center August 28, 2015 Page 6

Feel free to contact me if you have questions.

Sincerely,

Kamala Fishe Downing

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

Telephone: (651) 201-4112

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 09/14/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		245395	B. WING		08/13/2015
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 965 MCMILLAN STREET WORTHINGTON, MN 56187	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	-S	F 00	0	
	as your allegation on Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve for compliance upon the otance. Because you are our signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance.			
F 166 SS=D	on-site revisit of you validate that substa regulations has bee your verification. 483.10(f)(2) RIGHT	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with TO PROMPT EFFORTS TO NCES	F 16	6	9/22/15
	facility to resolve gr	ight to prompt efforts by the ievances the resident may se with respect to the behavior			
	by: Based on interview facility failed to follor regarding assistant (ADLs) for 1 of 1 reconcern of being definitions include: On 8/11/15, at 9:04 one aide on nights During continuous (8:55 a.m. to 9:45 a.	a.m. R31 stated there was ne was always kind of rude. observations on 8/12/15, from m. R31 was observed to from nursing staff to walk to		It is the facility's policy to investigate a resolve resident grievances. For R31: The facility respectfully disagrees with surveyor's description of the conversat the surveyor had with the SW (Social Services Director) and the surveyor's description of the SW's investigation of R31's concerns. The SW's handwritte report of the investigation included the following information: R31 reported to the	the ion f
ABOBATORY	L Z DIBECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

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

TITLE

Electronically Signed

09/07/2015

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

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245395	B. WING		08/	13/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI		10/2010	
CROSSE	OADS CARE CENTE	ER		965 MCMILLAN STREET WORTHINGTON, MN 56187			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		OULD BE	(X5) COMPLETION DATE	
F 166	the bathroom and to walk with her in R31's care plan da assist R31 with an walker. R31 was to transfers on and of abuse prevention paccurately report at The quarterly Minimindicated R31's was interviewed an nurse on at night. expect them to foll no reports of difficity at 2:19 p.m. soci R31 had ever told R31 to walk to the "Yes, I shared that last Thursday, that refused to provide [R31] tends to exacomplain against the working that night, any complaints. R3 further commented who tells a resider from the care plan. On 8/12/15, at 3:4 of investigation of handwritten docum following: The data identified, the alleger than the care plan.	waited until staff were available accordance with her care plan. ated 4/2/15, instructed staff to abulation using a front wheeled be assisted with toileting, and ff the toilet. R31's Individual blan indicated " could	F1	SW on 8-6-15 at 9:10 AM that man doesn't help me when I now SW asked resident if her call light and exactly what had happenes stated, "I had my light on and a man came in and said, "[R31] need?" R31 stated she told his the bathroom." R31 stated to SCNA responded, "Well then go he stood in the hallway not help my pants down or up." SW as pulling her pants down was difficult her. R31 replied, "No, I did it be supposed to help me." SW interviewed CNA in questic 8-7-15. SW described allegating him by R31. CNA stated to SV is usually in the bathroom by the there to answer her call light." do you do then?" CNA: "I wait bathroom door until she is don sure she gets back to bed safe "Do you assist her in pulling uppants?" CNA: "No, she has alw that." SW: "Would you assist he needed help?" CNA: "Yes Ma'a why I'm here." SW did interview a few more rewho require assistance with to regarding the care/assistance receiving. No concerns were wabout this CNA or any CNAs. The facility also respectfully diswith the surveyor's statement to stated "R31 is a miserable lady no recollection of making that	eed help." ght was on d. R31 tall black what do you n, "I need bW that the and then bing me pull ked R31 if icult for ut he is on on on made of /, "No, she e time I get SW: "What by the e and make ly." SW: her ays done er if she m, that's esidents leting hey are oiced agrees nat the SW " SW has		

	OF DEFICIENCIES OF CORRECTION				(X3) DATE SURVEY COMPLETED		
		245395	B. WING			08/1	13/2015
_	PROVIDER OR SUPPLIER	R		96	TREET ADDRESS, CITY, STATE, ZIP CODE 65 MCMILLAN STREET VORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 166	service, the possibl identified. The document had "interviewed a cares/assistance by voiced." No conclus not be determined the what the resolution	e contributing factors were not iment indicated that the facility few more Residents regarding a overnight aids-no concernstion was documented. It could from reading the document of investigation had identified, resident had been informed of	F 1	66	SW does recall telling surveyor that "is an unhappy lady". (SW has hear R31's daughter refer to her mother miserable lady". SW speculates the surveyors may have talked to R31's daughter during the survey and cor SW's statement about R31 being a unhappy lady with daughter's description of her mother being a miserable lade. The SW did talk with surveyors about R31's history of exaggerating details being prejudiced. R31's history of exaggeration and prejudice is address in her care plan and SW's quarterly documentation. Since the surveyor reported R31's concern to the SW, the SW has be checking with R31 daily, when SW work, to provide time for R31 to example and assistance from staff and offer education to R31 frequently regard importance of reporting her concern the Charge nurse. Staff education been completed. The facility's grievance policy and procedure has been reviewed and revised. Any concerns voiced by residents or family members will be written on the Suggestion/Concernand routed to related Department H (DH). If the concern meets the definition of a cities of actual or potential abuse/neglect Administrator shall be notified immand will delegate staff per the facility Abuse Prevention Plan (policy/procedure in initial online report with Olice in initial online re	ard as "a at s infused in ription dy.) but ls and essed en is at press er cares ing ing the ns to has es form leads finition t, the ediately ty's edure)	

AND DUAN OF CORDECTION DENTIFICATION NUMBER.		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245395	B. WING		08/	13/2015
	PROVIDER OR SUPPLIER	R	•	STREET ADDRESS, CITY, STATE, ZIP CODE 965 MCMILLAN STREET WORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 166	Continued From pa	ge 3	F1	Investigation will then be dapplicable DH. Results of investigation will be review and Director of Nursing, S Director and Administrator correction/resolution will be and findings/plan of correction/resolution will be and findings/plan of correction/resolution will be reviewed with the owithin seven (7) days by the Nursing, Social Services If Staff education will be confindings result in changes policy/procedure. If an inifiled with OHFC, the DON final investigation report with the initial report. Weekly follow-ups will be R31 to ensure R31's satistic results of this follow up with quarterly QA meeting to do faction/resolution have work or if modifications are indiffered are indiffered been revised. Any concerns voresidents or family member written on the Suggestion/and routed to related Depton (DH). If the concern meet of actual or potential abuston and will delegate staff per Abuse Prevention Plan (put of file an initial online reported).	of DH wed with the DH Social Services r, a plan of be determined ction/resolution concerned party he Director of Director or DH. mpleted if in itial report was I or SW will file a within 5 days of completed with sfaction. The ill be reviewed at letermine if plans been successful icated. colicy and ewed and biced by ers will be /Concerns form partment Heads ets the definition se/neglect, the iffied immediately the facility's policy/procedure)	

AND PLAN OF C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245395	B. WING			08/-	13/2015
	OVIDER OR SUPPLIER	3		96	TREET ADDRESS, CITY, STATE, ZIP CODE 65 MCMILLAN STREET ORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 225 48 SS=D IN A	een found guilty of nistreating resident ad a finding entere egistry concerning f residents or misa nd report any know ourt of law against ndicate unfitness fo	(c)(2) - (4) PORT IVIDUALS It employ individuals who have abusing, neglecting, or s by a court of law; or have d into the State nurse aide abuse, neglect, mistreatment ppropriation of their property; vledge it has of actions by a an employee, which would ir service as a nurse aide or the State nurse aide registry	F 1		Investigation will then be completed applicable DH. Results of DH investigation will be reviewed with the and Director of Nursing, Social Servicetor and Administrator, a plan of correction/resolution will be determined findings/plan of correction/resolution will be reviewed with the concerned within seven (7) days by the Director Nursing, Social Services Director of Staff education will be completed if findings result in changes in policy/procedure. If an initial report filed with OHFC, the DON or SW with final investigation report within 5 dathe initial report. SW will maintain a log of grievance outcomes which will be reviewed by QA Committee quarterly to determine resolution of grievances is effective modifications indicated.	ne DH vices f ned lution party or of DH. was ill file a ys of s and v the ne if	9/22/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245395	B. WING		08/13/2015
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 965 MCMILLAN STREET WORTHINGTON, MN 56187	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉTION
F 225	involving mistreatm including injuries of misappropriation of immediately to the to other officials in a through established State survey and control of the facility must have a survey and control of the facility must have a survey and control of the facility must have a survey and control of the facility must have a survey and control of the facility must have a survey and the facility must have a survey and in the facility must have a survey and in the facility must have a survey and the fac	resure that all alleged violations tent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law diprocedures (including to the ertification agency). The evidence that all alleged ughly investigated, and must ential abuse while the rogress. The evidence that all alleged ughly investigated, and must ential abuse while the rogress.	F 225		
	by: Based on interview facility failed to imm administrator and S thoroughly investiga unknown origin 1 or for abuse prohibition. Findings include: Review of the Resistant S/1/15, going forward R33 had a Resident.	State agency (SA) and ate an allegation of an injury of f 4 residents (R33) reviewed		The facility's policy is to ensure that incidents, accidents and alleged vicinvolving mistreatment, neglect or a including injuries of unknown source misappropriation of resident proper reported immediately to the Administ of the facility and to other officials in accordance with State law through established procedures (including to State survey and certification agency thoroughly investigates the same.	plations abuse, e and ty are strator o the

	OF DEFICIENCIES OF CORRECTION				(X3) DATE SURVEY COMPLETED	
		245395	B. WING		08/1	3/2015
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 965 MCMILLAN STREET WORTHINGTON, MN 56187	,	3/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 225	an injury of unknow of incident was ma "Describe EXACTL bruise found during left inner thigh 1 mcm there [sic] other section noted a boodrawn on left inner page of Resident In which indicated R3 which was marked as being 'confuse The form went on the notified on 5/26/15 nursing (DON) was a.m. (two days after administrator notificatime. The section of was void of an marked as word of an marked as a word of an marked and in the care plan date being to report abute R33 Minimum Data R33's cognition was required extensive bed mobility, transformed in the care plan date being to report abute R33 Minimum Data R33's cognition was required extensive bed mobility, transformed in the care plan date being to report abute when all the care plan date being to report abute was required extensive bed mobility, transformed in the care plan date being to report abute and word in the care plan date being to report abute and word in the care plan date being to report abute and word in the care plan date being to report abute a wor	wn origin in the groin. The time rked as a.m. The section Y what happened " reported " g AM cares-2 bruises noted on easures 1 cm. [centimeter] x 2 r measures 2 cm x 2 cm." The dy diagram which had a circle thigh, near the groin. The back neident Report had a box 3 had an unexplained injury "Yes." The form depicted R33 d' and 'totally disoriented. ' to note that social services at 7:00 a.m. The director of a notified on 5/26/15, at 8:30 or the incident happened). The cation was void of date and of notifying common entry point	F 225	The facility respectfully disagrees to incident should have been reported. State agency and that it did not the investigate this incident. The survey findings as stated on the 2567 (State of Deficiencies) do not state that the was no evidence to indicate that the incident was investigated by the fact staff nor do the findings state that it facility, after investigation, came to conclusion that the cause for the becould not be determined. The DOI investigate this incident as evidence the incident report. The DON state incident report "Unable to identify a contact surface for bruising (L) inneresident says "No" when asked if someone. Limited cognition, no verbody language indicating someone have mistreated her. Possibly ben from PT eval-exercise plan within I resident's chronic health conditions Quad muscle tight, holds legs tight Limited abduction." The DON also on the incident report that the resident on the incident report for R33 and investigation information was revie again by the DON subsequent to the surveyor's findings. The DON cam conclusion that the bruising was makely due to the placement of the resident's incontinence product insert/snap pants bunching up again thigh causing a bruise related to be Coumadin-bleed risk". The DON a interviewed the RCC and Charge Not the RCC and Char	d to the broughly eyor's atement here e cility the the ruise N did sed by es in the specific er thigh. hurt by erbal e may efit imits of s	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245395	B. WING			08/	13/2015
-	PROVIDER OR SUPPLIER	R	STREET ADDRESS, CITY, STATE, ZIP CODE 965 MCMILLAN STREET WORTHINGTON, MN 56187				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	administrator said, incidents that are a p.m. or when I get to true abuse." We tenotification (of adm form. I don't keep did not include the administrator. Abuse Prevention Finstructed staff to: "Investigation: All in changes of conditional tercations and acreports or allegation abuse will be taken investigated. Investigated. Investigated abuse will be taken investigated. Investigated are mandated report incidents, acreport incidents involving and actual or suspendistreatment, explored for property will be reported to the acreport incidents involving and actual or suspendistreatment, explored for property will be reported to the policy titled Immediate Reporting the property incidents acreported to the property will be reported to the property w	p.m. during an interview the "I truly believe we have no buse. I am notified before 10 up in am except in instances of II the staff to be sure and write inistrator) on the back of the a log." The back of the form	F 2	225	separately. After considering the loo of the bruise and possible causes, nurses came to the same conclusion independently of the DON. Retroact it is concluded that the bruising was caused by the bunching up of the incontinence product insert/snap parand the predisposition for bleeding/bruising due to Coumadin and limited abduction. Reeducation being provided to CNAs in small hur (individually and small groups) on oplacement of incontinence product avoid accidental injury and will be completed by 09/22/15. DON will randomly audit one reside each unit for six weeks for proper application of incontinence product pants by CNAs. Results of audits wereviewed at quarterly QA meeting to determine if plan of action is effection modifications indicated. For All Residents: The facility's Abuse Prevention Proper and investigation procedures has be reviewed and revised. The incident has been revised to include specific instructions to call the Administrator immediately if there is actual or sus mistreatment, abuse, neglect or misappropriation of resident's funds employee, family member or visitor resident sustains an injury requiring physician visit/transport to emerger	both on tively, seatts use is addles correct to ent on year, dures een report or expected as by an ; a g a	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245395	B. WING		08	/13/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 965 MCMILLAN STREET WORTHINGTON, MN 56187			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 225	Administrator date	ed 6/13/15, instructed staff to rator immediately when actual	F 2	room; an injury of unknown resident-to-resident alteror ("Immediately" means 24 as possible/practical afterneeds have been met but the end of the shift.) Call Administrator will be logg making the call and by the taking the call and also not incident report, including Administrator's response to whether to initiate report the incident is determined Administrator to be report the DON, DON's designed Service Director will file the as possible/practical but a end of the shift. In their and the composition of the shift. In their and the composition of the shift of the report online as soon as put no later than end of the Nurse's shift. The Director direct the full investigation final investigative report of shifts of the initial report of shifts of the shifts of the initial report of shifts of the shifts of the initial report of shifts of the shifts of the initial report of shifts of the shifts of the initial report of the shifts of the shifts of the shifts of the initial report of the shifts of the	cation. c/7/365 as soon r the resident's t no later than ls to the led by the nurse e Administrator oted on the the and decision as of to OHFC. If d by the table to OHFC, le or Social he report as soon no later than the labsence, the initial OHFC possible/practical he charge or of Nursing will he and will file the with OHFC within ort. Ally investigated f investigation ctor of Nursing, and leports and le also reviewed le Committee analysis is f further d. The Director of g of all incident d provide a		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			E SURVEY IPLETED	
		245395	B. WING		08/	13/2015
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 965 MCMILLAN STREET WORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		OULD BE	(X5) COMPLETION DATE
F 225 F 226 SS=D	policies and proced mistreatment, negle	P/IMPLMENT ETC POLICIES velop and implement written	F 2	committee each quarter for revenue further recommendations. Nursing staff has been re-educe the requirement to call the Admimmediately. The revised Abus Prevention Plan will be reviewed licensed nurses at an in-service September 22, 2015 that will be by the Director of Nursing and Administrator.	cated as to ninistrator se ed with e by e presented	9/22/15
	by: Based on interview facility failed to imm administrator and S thoroughly investigating unknown origin 1 of for abuse prohibition. Findings include: The facility's Abuse 4/16/08, informed s "Investigation: All in changes of conditional altercations and activations."	state agency (SA) and ate an allegation of an injury of 4 residents (R33) reviewed		The facility's policy is to ensure incidents, accidents and allege involving mistreatment, neglectincluding injuries of unknown semisappropriation of resident properted immediately to the Ad of the facility and to other officinaccordance with State law throughlished procedures (includes State survey and certification at thoroughly investigates the sare For R33:	d violations t or abuse, ource and operty are ministrator als in ugh ing to the gency) and ne.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245395	B. WING			08/1	13/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		. 0, 2010
CDOCCE	OADS CARE CENTS	D		96	65 MCMILLAN STREET		
CHUSSE	ROADS CARE CENTE	.n		W	ORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	abuse will be taken investigated. Investigated. Investigated. Investidentify what happe immediately after in exploitation or missoccurs or a report of "REPORTING AND are mandated report incidents, actinjuries of unknown change of conditional tercations and actinguries of unknown change of conditional tercations and actinguries of unknown change of conditional tercations and actinguries of unknown and actual or suspendistreatment, explor of property will be reported an injury of the administriction of the Resi 5/1/15, going forward Rayanda a Resider 5/24/15. The incided an injury of unknown of incident was man "Describe EXACTL bruise found during left inner thigh 1 mic community of the section noted a bood drawn on left inner thing the section noted a bood drawn on left inner	a seriously and thoroughly stigation is a process used to ened. Investigation begins incidents, mistreatment, appropriation of property of same is received." O RESPONSE: All employees of ters. Staff is expected to ecidents, injuries (including in origin), medication errors, in, resident to resident stual or suspected abuse to the luty or the Director of Nursing, ector and the Administrator. Injury, unexplained injuries ected abuse, neglect, obtation and misappropriation reported to the Minnesota alth (online) within 24 hours." In Delegation of Authority for the of Actual or Alleged ect or Abuse in Absence of de 6/13/15, instructed staff to ator immediately when actual	F 2	226	incident should have been reported State agency and that it did not tho investigate this incident. The surve findings as stated on the 2567 (State of Deficiencies) do not state that the was no evidence to indicate that the incident was investigated by the fact staff nor do the findings state that it facility, after investigation, came to conclusion that the cause for the brown could not be determined. The DON investigate this incident as evidence the incident report. The DON state incident report "Unable to identify scontact surface for bruising (L) inner Resident says "No" when asked if his someone. Limited cognition, no vebody language indicating someone have mistreated her. Possibly benefrom PT eval-exercise plan within litresident's chronic health conditions Quad muscle tight, holds legs tight. Limited abduction." The DON also on the incident report that the resid "on Coumadin-bleed risk". The incident report for R33 and investigation information was review again by the DON subsequent to the surveyor's findings. The DON came conclusion that the bruising was medikely due to the placement of the resident's incontinence product insert/snap pants bunching up agait thigh causing a bruise related to be Coumadin-bleed risk". The DON alinterviewed the RCC and Charge N separately. After considering the loof the bruise and possible causes,	roughly eyor's tement ere exility the tuise I did ed by s in the pecific er thigh. nurt by rbal may efit mits of . noted ent is wed extended to the ost the ing "on so lurse cation	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	P) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		245395	B. WING			00/-	12/2015	
NAME OF I	PROVIDER OR SUPPLIEF				TREET ADDRESS, CITY, STATE, ZIP CODE	UO/	13/2015	
INAIVIL OI I	THOUBLITON 30FF LILI	1	965 MCMILLAN STREET					
CROSSF	ROADS CARE CENTI	≣R			ORTHINGTON, MN 56187			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 226	which indicated R3 which was marked as being 'confused form went on to no on 5/26/15, at 7:00 (DON) was notified days after the incide administrator notifitime. The section was void of an match the care plan date being to report about R33 Minimum Dat R33's cognition was required extensive bed mobility, transtoileting. On 8/12/15, at 2:1 stated, "We have immediately. We have immediately. We have or neglect was abuse we let state When asked when administrator was we do not write it to have kept a recordincident had not be on 8/12/15, at 3:2 administrator said incidents that are a 10:00 p.m. or whe instances of true as sure and write not the back of the for	33 had an unexplained injury "Yes." The form depicted R33 d' and 'totally disoriented.' The ote that social services notified a.m. The director of nursing d on 5/26/15, at 8:30 a.m. (two dent happened). The ication was void of date and of notifying common entry point	F 2	226	nurses came to the same conclusice independently of the DON. Retroact it is concluded that the bruising was caused by the bunching up of the incontinence product insert/snap parand the predisposition for bleeding/bruising due to Coumadin and limited abduction. Reeducation being provided to CNAs in small hurst (individually and small groups) on opplacement of incontinence product avoid accidental injury and will be completed by 09/22/15. DON will randomly audit one reside each unit for six weeks for proper application of incontinence product pants by CNAs. Results of audits wereviewed at quarterly QA meeting to determine if plan of action is effection modifications indicated. For All Residents: The facility's Abuse Prevention Profincluding but not limited to abuse prevention policies, reporting proceand investigation procedures has been revised to include specific instructions to call the Administrato immediately if there is actual or susmistreatment, abuse, neglect or misappropriation of resident's fundamental mistreatment, abuse, neglect or misappropriation of resident's fundamental mistreatment, abuse, neglect or misappropriation of resident's fundamental mistreatment in the programment of the mistreatment of the mistreat	ents use a is addles correct to ent on seen report or expected so by an expected so		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245395	B. WING		08/	13/2015	
_	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CO 965 MCMILLAN STREET WORTHINGTON, MN 56187			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE	
F 226	Continued From pa	ge 12	F 2.	("Immediately" means 24/7/3 as possible/practical after the needs have been met but not the end of the shift.) Calls to Administrator will be logged making the call and by the A taking the call and also note incident report, including the Administrator's response and to whether to initiate report to the incident is determined by Administrator to be reportable the DON, DON's designee of Service Director will file their as possible/practical but not end of the shift. In their absorbance of the Service of the shift. In their absorbance of the full investigation are final investigative report with five days of the initial report. All incidents are thoroughly in by facility staff. Results of investigative report and Administrator. Incident reports social Services Director and Administrator. Incident reports of investigation are and by the Risk Management Coweekly and a root cause and completed to determine if fur action/follow-up is needed. Thursing will maintain a log of reports going forward and prosummary report of same to the committee each quarter for reports going forward and prosummary report of same to the committee each quarter for reports going forward and prosummary report of same to the committee each quarter for reports going forward and prosummary report of same to the committee each quarter for reports going forward and prosummary report of same to the committee each quarter for reports going forward and prosummary report of same to the committee each quarter for reports going forward and prosummary report of same to the committee each quarter for reports going forward and prosummary report of same to the committee each quarter for reports going forward and prosummary report of same to the committee each quarter for reports going forward and prosummary report of same to the committee each quarter for reports going forward and prosummary reports going forward and prosummary reports going forward and prosummary reports going forward and prosume for the formary for the formary for the formary for the fo	e resident's or later than to the by the nurse administrator don the don's of OHFC. If y the decision as of OHFC, or Social report as soon later than the ence, the tial OHFC esible/practical Charge of Nursing will not will file the from OHFC within the of Nursing, don's and decision as the OHFC with a decision as the one of the Nursing and the OHFC with a decision as the one of the Nursing with the original decision as the output of the Nursing with the original decision as the one of the Nursing with the original decision as the one of the Nursing with the original decision as the original decision		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONS			(X3) DATE SURVEY COMPLETED	
		245395	B. WING			08/13/2015	
	PROVIDER OR SUPPLIER	R		96	TREET ADDRESS, CITY, STATE, ZIP CODE 65 MCMILLAN STREET /ORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329 SS=E	483.25(I) DRUG RE UNNECESSARY D Each resident's dru unnecessary drugs drug when used in duplicate therapy); without adequate mindications for its us adverse consequer should be reduced combinations of the Based on a compreresident, the facility who have not used given these drugs utherapy is necessar as diagnosed and crecord; and residen drugs receive gradu behavioral intervent	EGIMEN IS FREE FROM RUGS g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or conitoring; or without adequate se; or in the presence of aces which indicate the dose or discontinued; or any	F 2		Nursing staff has been re-educated the requirement to call the Administ immediately. The revised Abuse Prevention Plan will be reviewed wilicensed nurses at an in-service by September 22, 2015 that will be preby the Director of Nursing and the Administrator.	rator th	9/22/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245395	B. WING			08/1	13/2015
	PROVIDER OR SUPPLIER	R		9	TREET ADDRESS, CITY, STATE, ZIP CODE 65 MCMILLAN STREET VORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	This REQUIREMENT by: Based on observatoreview the facility factories (R49, R2, R20) had psychotropic medical Findings include: R49 was observed asleep on the reclining. At 8:30 a.m. R49 with dining room table. At 9:45 a.m. R49 with the hallway from hewith a staff person awaist and was note then assisted her total to the control of the	ion, interview and document illed to ensure 3 of 6 residents adequate monitoring for ations. on 8/12/15, at 7:27 a.m. Iter in the common area was observed seated at the was observed ambulate down for room to the common area and a transfer belt around her d with unsteady gait. Staff of the recliner. It was again observed idently gait unsteady and was 19 was noted to have a flat cluded dementia with ince, insomnia and dysthymic form admission face sheet dition the admission face sheet sion date of 6/1/15. Admission indicated R49 received both intidepressant medications at R49 had behaviors. a Assessment (CAA) dated R49 was at risk for falls, aired balance/gait and used Psychotropic drug medication indicated R49 used antipsychotic medications.	F3	29	It is the facility's policy is that each resident's drug regimen will be free unnecessary drugs. Survey findings state that R49, R2, R20 records did not have documer of monitoring for orthostatic hypote The Plan of Correction for resident R2 and R20 is the same as for all residents. The facility's policy for use of psychmedications has been reviewed an revised to include baseline orthostation monitoring for all residents on psychotropic medications during the MDS admission assessment refere window. Orthostatic blood pressure be monitored thereafter on monthly by Charge Nurses and reported to Resident Care Coordinators (RCC) will audit monthly to ensure completed and the complete of the comp	and ntation nsion. s R49, noactive d atic B/P e initial ence es will / basis b. RCC etion. to y cant tes urses	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		E SURVEY PLETED
		245395	B. WING		08/	13/2015
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 965 MCMILLAN STREET WORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329	to monitor for responses resident physical and not indicate address monitor for orthostal R49's psychotropic 6/21/15, indicated reffects related to us plan directed to moneffects, orthostatic movement disorder R49's Physician's Construction revealed the following revealed the following revealed the following responses (mood smilligrams (mg) by (TID) for dementia remeron (antidep daily for dysthymic revealed the medic documentation of the floor sustained however had not been done incident. On 8/12/15, at 2:25 BP's were usually the doctor had ordered orthostatic B/P's had 6/1/15, after she were significant to the floor static B/P's had 6/1/15, after she were significant to the floor static B/P's had 6/1/15, after she were significant to the floor static B/P's had 6/1/15, after she were significant to the floor static B/P's had 6/1/15, after she were significant to the floor significant	side effects. CAA directed staff onse and any changes in and mental status however did is when and how often to atic BP's. drug use care plan dated and any changes are protocol and monitor and any changes are protocol and monitor and places. Orders Sheet dated 7/22/15, and orders: stabilizer) sprinkles 250 mouth (PO) three times daily with behavioral disturbance. The morning only give one disorder. PO morning only give daily for avioral disturbance.	F 329	Documentation records will be monthly by the DON. Results of be reviewed at quarterly QA modetermine if plan of action is efficient modifications indicated.	f audits will eeting to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245395	B. WING			08/	13/2015
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, Z 965 MCMILLAN STREET WORTHINGTON, MN 56187	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD THE APPROPI	BE	(X5) COMPLETION DATE
F 329	facility protocol was orthostatic blood presidents who were and were at risk for be done monthly buresident was not an or did not reposition stated when a resident efacility orthostated when a resident efacility orthostated one but at times it them. -At 1:06 p.m. DON to obtain orthostatic were admitted due she acknowledged attempted later to ostated the resident responsible for makes assessment were at CP should have call assessment had be CP as the facility has R2's quarterly MDS was admitted to the diagnoses included schizoaffective discontrol of the diagnoses discontrol of the diagnoses discontrol of the	a p.m. when asked what the for monitoring/checking essures DON stated for all on psychotropic medications falls they were supposed to at would be deferred if a abulating, did not transfer self a themselves. DON further lent was initially admitted to ic BP's were supposed to be would be difficult to obtain stated although it was difficult a BP's initially when residents to adjustment and behaviors the nurses should have btain the BP's. DON further care coordinators were sing sure the DISCUS accurately completed and the uight it but thought the een done prior to the current ad switched pharmacists. dated 5/11/15, indicated R2 a facility on 2/2/09. Admission depression, psychosis, order, anxiety, heart failure, Set (MDS) dated 8/13/15, orgitively intact. R2 required mobility, transfers, toilet use,	F3	329			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245395	B. WING		····	08/	13/2015	
NAME OF PROVIDER OR SUPPLIER CROSSROADS CARE CENTER				9	TREET ADDRESS, CITY, STATE, ZIP CODE 65 MCMILLAN STREET VORTHINGTON, MN 56187			
PREFIX (EACH DEF	ICIENC	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
psychosis, had of long term is evidenced by R2's physicia Zyprexa (anti A review of the revealed the documentation antipsychotic The manufact (olanzapine) for orthostatic pressure who may induce of with dizziness bradycardia (patients synchosociousness patients with medications I side effects in lightheaded in constipation, R20's quarter R20 was admission dia depression, a R20's quarter R20's quarter R20 was admission dia depression, a R20's quarter R20's quar	n date ad dep schizo poor n orde psych are medical turers indical the slow hope (as and knowrknown hay increasely MD hitted the agnosting school of the slow hope (as and knowrknown hay increasely MD hitted the agnosting school of the slow hope (as and sc	and 8/23/12, indicated R2 had bressed mood related to history affective disorder as grooming. Bers dated 8/11/15, included otic) 15 mg at bedtime. Clical record from 8/13/15, al record lacked rthostatic BPs monthly for the cation Zyprexa. Package insert for Zyprexa ted patients would be at risk tension (a fall in blood nging positions) olanzapine atic hypotension associated bycardia (fast heart rate), and in some a temporary loss of posture), especially in heart disease or with other to cause hypotension. Other clude: drowsiness, dizziness, tomach upset, dry mouth, used appetite, or weight gain. S dated 7/17/15, indicated to the facility on 6/8/10. es included hypertension,	F3	29				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245395	B. WING			08/13/2015		
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP COD 965 MCMILLAN STREET WORTHINGTON, MN 56187	E			
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 329	exhibit behaviors. In 8/13/15, indicated F as evidenced by disparticipating with cablunted affect, disconsers, would not all cares/therapy at time R20's physician orce R20 received Risperage A review of the medic documentation of oantipsychotic medical for orthostatic hypopressure when chamay induce orthost with dizziness, tach is some patients syresulting from insuffers expecially during the Other side effects of dizziness, lighthead weight gain, or tired On 8/13/15, at 10:5 (LPN)-B stated they pressures on admist they may do them in have an indication of On 8/13/15, at 11:1	/13/15, indicated R20 did not a addition care Plan dated R20 had history of depression splay of little interest in ares, therapy, activities, onnect. R20 was resistive to ow staff to provide res. Pers dated 8/12/15, indicated ardal 1.0 mg at bedtime. Rical record from 8/13/15, all record lacked arthostatic BPs monthly for the reation Risperdal. Repackage insert for Risperdal red patients would be at risk tension (a fall in blood reging positions) risperidone ratic hypotension associated yeardia (fast heart rate), and recope (loss of consciousness ficient blood flow to the brain), re initial dose-titration period. The record practical nurse of do orthostatic blood sion. LPN-A further stated of physician orders it or they	F3	29				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	E SURVEY IPLETED
		245395	B. WING		08/	13/2015
NAME OF PROVIDER OR SUPPLIER CROSSROADS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 965 MCMILLAN STREET WORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 329	and with fall assessments. They do not routinely do blood pressures if ambulatory, or if not symptomatic with dizziness. The Medication Monitoring and Management policy dated 4/1/15, indicated"consultant pharmacist use the standing monitoring orders to		F 3	29		
F 356 SS=C			F 3	56		8/17/15
	a daily basis: o Facility name. o The current date. o The total number by the following cat unlicensed nursing resident care per sl - Registered nu - Licensed prace	rses. tical nurses or licensed as defined under State law). e aides.				
	The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.					
	make nurse staffing	oon oral or written request, g data available to the public not to exceed the community				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245395	B. WING		08/1	3/2015
NAME OF PROVIDER OR SUPPLIER CROSSROADS CARE CENTER			9	TREET ADDRESS, CITY, STATE, ZIP CODE 65 MCMILLAN STREET VORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 356	standard. The facility must m staffing data for a r required by State la	age 20 aintain the posted daily nurse minimum of 18 months, or as aw, whichever is greater. NT is not met as evidenced	F 356			
	by: Based on observa review, the facility of Nursing Staff Direct Care (RoNS) was of hours worked. This affect all 39 resider family and visitors of information. Findings include: During the initial to RoNS was observe facility's main lobby facility name, curre labor for registered practical nurses (Li	tion, interview and document railed to ensure the Report of the Responsible For Resident updated daily to reflect actual a practice had the potential to the system of the resided in the facility, who wished to view this are on 8/10/15, at 3:30 p.m. the ed posted on the wall in the one of the resident census, hours of the resident census, hours of the resident census, and nursing assistants		It is the facility's policy that the Rel Nursing Staff Directly Responsible Resident Care (RoNS) is posted in lobby on a daily basis at beginning shift. The facility's policy has been review and revised to ensure that this requirement is met. The Staffing Scheduler is responsible for postin staffing information during weekda the East Charge Nurse is designate post staffing information on weeker in absence of Staffing Scheduler. The East Charge Nurse will be advised Staffing Scheduler will be absent.	for the of each wed gys and ed to nds and the	
	labor for registered nurses (RNs), licensed practical nurses (LPNs) and nursing assistants (NAs). The posting was dated 8/7/15, and did not reflect the actual staff working at the start of the survey. During subsequent observations from 8/10/15 to 8/12/15, of the RoNS the following was identified: On 8/10/15, at 3:30 p.m. the RoNS was dated 8/7/15, and a census of 37. Surveyors were told that there were 39 residents in the facility at the time the survey entered the building. On 8/10/15, at 5:15 p.m. RN-A observed posting a new RoNS dated 8/10/15, and a census of 40. On 8/11/15, at 8:23 a.m. the posted RoNS was			These changes were reviewed on 08/13/15 with Staffing Scheduler at Charge Nurses and on 8/17/15 with who are also nursing unit supervisor. The DON will audit randomly, at least twice a week for six weeks and we thereafter, to ensure that the RoNS posted with correct date, correct cand staffing information and report of audits at the next Quarterly QA rat which time the results of the audite reviewed to determine if plan of	n RCCs ors. ast ekly S is ensus results meeting lits will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245395	B. WING _		08/	13/2015
NAME OF PROVIDER OR SUPPLIER CROSSROADS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 965 MCMILLAN STREET WORTHINGTON, MN 56187	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 356	dated 8/11/15, cens On 8/12/15, at 7:26 dated 8/11/15, cens On 8/12/15, at 10:0 dated 8/11/15, at 10:0 dated 8/11/15, at 10:0 dated 8/11/15, at 10:0 survey the current of 39 and the RoNS we current census of the Con 8/13/15, at 11:5 stated she was respected and know who we the actual hours on current one daily or - At 1:47 p.m. the swhat was posted for the day were the scheduled were to were received after until the next day, we - At 3:19 p.m. direct staffing hours are to updated as needed. The facility provided Staffing Numbers of "1. Each morning the and the number of directly responsible posted in a promine."	sus 40. 7 a.m. the posted RoNS was sus 40. a.m. the posted RoNS was sus 40. 2 a.m. the posted RoNS was sus 40. On all days of the census of the facility remained ras not updated to reflect the ne facility. 6 a.m. the staffing coordinator consible for updating the ceived them. She added she ras responsible for updating the RoNS or posting the national the week-ends. Taffing coordinator stated that it staff posting when she left it was not changed when she came. To for nurses stated the obe posted every morning and the posted every morning and the number of Licensed Nurse and personal for resident care will be entilocation (accessible to	F 35	is effective/or modifications indications indications.	ited.	
	readable format."	rs) and in a clear and RMACEUTICAL SVC - EDURES, RPH	F 42	5		9/22/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED		
		245395	B. WING _		08/	13/2015		
NAME OF PROVIDER OR SUPPLIER CROSSROADS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 965 MCMILLAN STREET WORTHINGTON, MN 56187				
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 425	The facility must prodrugs and biological them under an agres §483.75(h) of this punction of a licensed personal law permits, but on supervision of a licensed personal facility must prove (including proceduracquiring, receiving administering of all the needs of each. The facility must era licensed pharmacensed phar	ovide routine and emergency als to its residents, or obtain element described in part. The facility may permit nel to administer drugs if State ly under the general ensed nurse. ide pharmaceutical services res that assure the accurate g, dispensing, and drugs and biologicals) to meet resident. Imploy or obtain the services of cist who provides consultation e provision of pharmacy	F 42	5				
	by: Based on observareview, the facility for medications were redication carts. It ensure medications dated when opened attended when opened attended with the conducted of medical conducted of medical censed practical redications.	NT is not met as evidenced tion, interview and document ailed to ensure expired not available for use in 2 of 2 in addition, the facility failed to swith a short shelf life were d. 12 a.m. during a tour was cation storage areas with lurse (LPN)-B, and registered provided access to the carturing the tour the following		It is the facility's policy to prove pharmacy services including per that assure the accurate acquireceiving, dispensing and admall drugs and biologicals to me needs of the resident. In additifacility's policy to employ or observices of a licensed pharmal provides consultation on all as provision of pharmacy services facility, establishes a system of receipt and disposition of all confugs/expired drugs in sufficies support an accurate reconciliate determines that drug records as	procedures iring, ninistering of set the ion it is the stain the cist that spects of the s in the of records of controlled nt detail to tion and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
245395		B. WING	B. WING		08/13/2015		
NAME OF PROVIDER OR SUPPLIER CROSSROADS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 965 MCMILLAN STREET WORTHINGTON, MN 56187				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425			F	125	and that an accounting of all control medications is maintained and peri reconciled. The facility's policy and procedure for identifying and removing expired medications and treatment supplies been reviewed and revised. Expired medications and treatment supplies identified during survey have been disposed of and replaced. Opened/undated medications have been disposed of and replaced. All nursing staff (licensed nurses and TMAs) is responsible for ensuring the medications with a short shelf life and the dated when opened, before administration. Nursing staff has been reminded to check expiration dates medications prior to administration date medications with a short life we opened. An in-service will be held to 9/22/15 to review facility policies and procedures with licensed nursing staff medication assistants.	olled odically for s has ed s s also and that are stering and to then by and	
					The DON or delegated RCC and C Nurse from each unit will audit med carts and medication storage areas monthly, remove/dispose of any ex medications/treatment supplies and undated medications with a short lit replace if needed and document fir Results of audits will be reviewed a next Quarterly QA meeting to deter the plan of action is effective or	dication s pired d/or fe, adings. t the	

l l	
245395 B. WING 08/13/20	/2015
NAME OF PROVIDER OR SUPPLIER CROSSROADS CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 965 MCMILLAN STREET WORTHINGTON, MN 56187	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	(X5) COMPLETION DATE
F 425 Continued From page 24 pouch and only open when ready for use. Safely throw away SEREVENT DISKUS in the trash 6 weeks after you open the foll pouch or when the counter reads 0, whichever comes first." The Advair Diskus package insert information from GlaxoSmithKline LLC dated 4/14, directed the following information on how to store the medication. "Store ADVAIR DISKUS in the unopened foil pouch and only open when ready for use. Safely throw away ADVAIR DISKUS in the trash 1 month after you open the foil pouch or when the counter reads 0, whichever comes first." East unit On 8/13/15, at 10:56 a.m. the medication storage tour was completed with RN- E. During the tour the following concerns were identifiedMulti-Vitamin with mineral 100 tablet bottle unopened with expiration date 10/14Calcium Carbonate (promote bone growth) 1250 mg box with 100 tablets with expiration date 7/15. RN-E stated expired medications should be sent back to the pharmacy or destroyed. Medication storage on the long term care unit was conducted with LPN-B on 8/13/15, at 1:15 p.m. and the following discrepancies were noted and LPN-B concurred: - Triamcinolone Acetatomide Cream (used to treat various skin conditions) 1% for R18, one tub expired on 6/15 and a second tub on 7/15 McKesson Vit A and D o intment expired in 2014, the month was not readable.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED	
		245395	B. WING _		08	/13/2015
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CO 965 MCMILLAN STREET WORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 425	expired 10/14 Solution of Hydrogagent) 3% expired - Migraine Formula 24 capsules unope - One Daily Multivit unopened, expired - Levemir Insulin (no blood sugar) dispending pharmacy, was open opened for R9. The Levemir Insulin from Novo Nordisk following information medication. "Vials: After initial use, via refrigerator, never in not possible, the inunrefrigerated at round (86°F) as long as it and away from direct LEVEMIR vials show initial use. Unrefrige discarded 42 day of the refrigerator. LEVEMIR FlexTougather initial use, the NOT be stored in a stored with the need (in use) LEVEMIR heat and light at round (86°F). Unrefrigera should be discarded kept out of the refrigerator. The undated Storage in the storage in the refrigeration of the refrigeral should be discarded kept out of the refrigeral should be discarded kept out of the refrigeral should storage in the storage i	gen Peroxide (germicidal 7/15, for two bottles. (medication for headaches), ned box expired 11/14. amin with Minerals 100 tablets, 3/15. nedication used to control nsed 7/2/15, from the ened, was not dated when an package insert information dated 2/15, directed the enent on how to store the energy as a cool as possible of the energy as a cool as possible of the energy after they are first kept out the energy after they are first kept out the energy after the energy after the energy after the energy after they are first kept out the energy after they are first they are	F 42	25		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	MULTIPLE CONSTRUCTION (X3 UILDING		X3) DATE SURVEY COMPLETED	
		245395	B. WING _		08/	13/2015	
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP COE 965 MCMILLAN STREET WORTHINGTON, MN 56187			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 428 SS=E	this facility. All such 483.60(c) DRUG R IRREGULAR, ACT The drug regimen of reviewed at least of pharmacist. The pharmacist muthe attending physical pharmacist.	ations are available for use in medications are destroyed" EGIMEN REVIEW, REPORT	F 42			9/9/15	
	by: Based on observareview, the facility's to ensure monitorin 5 residents (R49, Fantipsychotic medicunnecessary medicunneces	on 8/12/15, at 7:27 a.m. her in the common area vas observed seated at the vas observed ambulate down her room to the common area and a transfer belt around her d with unsteady gait. Staff		It is the facility's policy to enseach resident's drug regimen at least monthly by a licensed that the pharmacist reports ar irregularities to the attending and the Director of Nursing ar reports are acted upon. A lice pharmacist does review all records at least monthly and uby a physician and/or nursing there is a change in a residenthat might be related to medicate The plan of correction for R49 R20 is the same as for all resident reviewed and revised to each resident's drug regimen	is reviewed pharmacist; by physician and these nsed sident upon request staff when t's condition ations. 9, R2 and idents. dure has ensure that		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245395	B. WING			08/13/2015	
	PROVIDER OR SUPPLIER	R		96	TREET ADDRESS, CITY, STATE, ZIP CODE 55 MCMILLAN STREET ORTHINGTON, MN 56187	33.	,
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	(X5) COMPLETION DATE		
F 428	redirected to sit. Raaffect. R49's diagnoses in behavioral disturbated disorder obtained from the dated 6/2/15. In additional revealed an admission Minimum Data Set R49 received both antidepressant med R49 had behaviors. R49's fall Care Area 6/14/15, indicated From wandered, had impan antidepressant. CAA dated 6/14/15 antidepressant and The CAA indicated psychotropic drug stomonitor for responsible to monitor for responsible to monitor for orthostates. R49's psychotropic 6/21/15, indicated From the disorder effects related to us plan directed to mone effects, orthostatic's movement disorder. R49's Physician's Crevealed the following pakote (mood similigrams (mg) by	cluded dementia with nce, insomnia and dysthymic rom admission face sheet dition the admission face sheet sion date of 6/1/15. Admission (MDS) dated 6/8/15, indicated antipsychotic and dications daily and was noted antipsychotic and dications daily and was noted antipsychotic drug medication, indicated R49 was at risk for falls, aired balance/gait and used Psychotropic drug medication, indicated R49 used antipsychotic medications. R49 was at risk for side effects. CAA directed staff onse and any changes in the defects and how often to atic BP's. drug use care plan dated R49 was at risk for adverse se of medications. The care intor R49 for potential side is per protocol and monitor DISCUS per policy.	F 4	428	at least monthly by a licensed phar that the pharmacist reports irregula the attending physician and DON a reports are acted upon in order to minimize or prevent adverse consequences and identify significatisks to the extent possible. See POC for F329 regarding chang policy/procedure for monitoring orth B/P. All pharmacy consultation reports we received by the Health Information Assistant (HIA). The Summary Repfrom the Pharmacy Consultant revibe given to the DON for review. Incresident's reports will be given to resident's response will be held unscheduled house visit unless deem urgent, at which time it will be faxed physician same day for review. Nurrecommendation reports will be addressed by each unit's RCC in collaboration with DON as needed. Interdisciplinary Team (IDT) will revibarmacy recommendations if IDT is indicated. All affected Department Heads and HIA were updated on policy/procedure revisions by 8/17/Consulting Pharmacist reviewed are approved policy/procedure revision during in-house visit on 9/1/15. Medicated Department Picture of the procedure revisions during house visits on 9/9/15. Medicated Department Picture of the policy/procedure revisions during house visits on 9/9/15. Medicated Department Picture of the policy/procedure revisions during house visits on 9/9/16.	rities to nd that ant ges to nostatic will be nort ew will lividual ors sting at to sing The iew review at 15. ad s dical dure /15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
		245395	B. WING		08/	13/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 965 MCMILLAN STREET WORTHINGTON, MN 5618	, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 428	-Remeron (antidep daily for dysthymic -Risperdal 0.25 mg dementia with behavior and the revealed the medic documentation of (BPs). In addition i lowered to the floo sustained however had not been done incident. During further documentation of the Consultant phamonthly review had with other previous 6/2/15, and had be clinical problems where the Consultant phamonthly review had with other previous 6/2/15, and had be clinical problems where the consultant phamonth of the consultant phamonth of the consultant B/P's had 1/15, after she where the consultant phamonth of the consultant p	pressant) 30 mg PO give one disorder. g PO morning only give daily for avioral disturbance. dical record from 6/1/15, cal record lacked orthostatic blood pressure indicated R49 had been in on 7/13/15, no injuries orthostatic blood pressures either at the time of the farmacist's Medication Regiment diast been completed 8/3/15, and sen indicated no significant were noted. 5 p.m. RN-A stated orthostatic done on admission and if the diathem. RN-A verified ad not been done on admission ent through the admit wither stated R49 had refused the time of admission but had oted. 40 a.m. via telephone the cist (CP) stated he was not cility orthostatic blood rotocol and would expect the erorthostatic BP's if resident	F 4	responsible for auditing regimens monthly and of his findings as noted include CP recommend physicians and others; and procedures that approached management; results of medication storage, date and disposition of medication pass audits assessments, including indicated for monitoring medications that pose effects/consequences identification of trends medication use in the form the CP will provide the QA Committee at all quince meetings. The QA Conto determine if the plane effective or modification made.	providing a report d above. Reports dations for review of policy oply to medication of audits for ating medications; s; completion of g orthostatic B/Ps, g response to a risk for adverse to the resident; and in psychoactive facility and GDRs. ese reports to the uarterly QA mmittee will review of action is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		245395	B. WING _		08	/13/2015
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CO 965 MCMILLAN STREET WORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 428	was on atypical ant On 8/13/15, at 12:1 facility protocol was orthostatic blood pr (DON) stated for al psychotropic medic falls they were supp would be deferred i ambulating, did not reposition themselv a resident was initia orthostatic BP's we times it would be di -At 1:06 p.m. DON to obtain orthostatic were admitted due she acknowledged attempted later to o R2's quarterly MDS was admitted to the diagnoses included schizoaffective disc COPD, and CHF. The MDS dated 8/1 cognitively intact. R mobility, transfers, assist with dressing The CAA dated 8/1 exhibit behaviors. The Care Plan date psychosis depresse	ic BP's for R49 because she ipsychotic medications. 3 p.m. when asked what the for monitoring/checking essures director of nursing residents who were on eations and were at risk for bosed to be done monthly but fa resident was not transfer self or did not res. DON further stated when ally admitted to the facility re supposed to be done but at fficult to obtain them. stated although it was difficult be BP's initially when residents to adjustment and behaviors the nurses should have obtain the BP's. Indicated R2 a facility on 2/2/09. Admission depression, psychosis, order, anxiety, heart failure,	F 42	8		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY PLETED	
		245395	B. WING			08/	13/2015
	PROVIDER OR SUPPLIER	R		965	REET ADDRESS, CITY, STATE, ZIP CODE S MCMILLAN STREET DRTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	Physician orders da 15 mg at bedtime. A review of the medic documentation of o (BPs) monthly for the Zyprexa. The manufacturers (olanzapine) indicate for orthostatic hypopressure when chamay induce orthost with dizziness, tach bradycardia (slow high patients syncope (a consciousness and patients with known medications known side effects may indightheadedness, stronstipation, increased on 8/13/15, at 10:5 (LPN)-B stated they pressures on admist they may do them in have an indication of the consciousness and patients with fall assess they may do them in the pressures on admist they may do them in the consciousness and oblood pressures symptomatic with don 8/13/15, at 11:1 orthostatic blood pressures symptomatic with don 8/13/15, at 11:4 consultant pharmace.	dical record from 8/13/15, al record lacked rthostatic blood pressure ne antipsychotic medication package insert for Zyprexa red patients would be at risk tension (a fall in blood nging positions) olanzapine atic hypotension associated ycardia (fast heart rate), and in some a temporary loss of posture), especially in heart disease or with other to cause hypotension." Other clude: drowsiness, dizziness, comach upset, dry mouth, sed appetite, or weight gain. 7 a.m. licensed practical nurse of do orthostatic blood sion. LPN-A further stated f physician orders it or they for it. 1 a.m. DON stated they do essures with initial admission sments. They do not routinely if ambulatory, or if not	F 4	428			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI IER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED	
		245395	B. WING	 	08	/13/2015
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP COL 965 MCMILLAN STREET WORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 428	orthostatic blood prediction problematic medical resident had falls he check the orthostate. R20's quarterly MD R20 was admitted and Admission diagnost depression, and so the MDS dated 8/1 two person assist which to the CAA dated 8/1 exhibit behaviors. The Care Plan date history of depression little interest in part activities, blunted a resistive to cares, where the care of the medical commentation of the medical documentation of the care of the medical commentation of the care of the medical commentation of the care of the medical commentation of the care of the care of the medical commentation of the care of the care of the medical commentation of the care of the car	the facility to check the ressures if resident was on ations. CP acknowledged if a rewould expect the facility to ic blood pressures. S dated 7/17/15, indicated to the facility on 6/8/10. resincluded hypertension, hizophrenia. 13/15, indicated R20 required with bed mobility, transfers, sing. 3/15, indicated R20 did not red 8/13/15, indicated R20 had on as evidenced by display of icipating with cares, therapy, ffect, disconnect. R20 was would not allow staff to provide nes. ated 8/12/15, included rams (mg) at bedtime.	F 4	28		
	Risperdal. The manufacturer's (risperidone) indicator orthostatic hypo	s package insert for Risperdal ted patients would be at risk tension (a fall in blood nging positions) risperidone				

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245395	B. WING _		08/	13/2015
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 965 MCMILLAN STREET WORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDER OF THE APPRECED TO THE APPRECED TO THE APPRECED OF	JLD BE	(X5) COMPLETION DATE
F 428	with dizziness, tach is some patients sy resulting from insuf especially during th Other side effects of dizziness, lighthead weight gain, or tired. On 8/13/15, at 10:5 orthostatic blood produrther stated they norders it or they have orders it or they have orders it or they have on 8/13/15, at 11:1 orthostatic blood production of the Medication Mopolicy dated 4/1/15, pharmacist use the assist in assessing effectiveness, and production of the modicy." On 8/13/15, at 11:4 consultant pharmacist and would expect the orthostatic blood problematic medical resident had falls hecheck the orthostatic blood problematic medical resident had falls hecheck the orthostatic blood problematic medical resident had falls hecheck the orthostatic blood problematic medical resident had falls hecheck the orthostatic blood problematic medical resident had falls hecheck the orthostatic blood problematic medical resident had falls hecheck the orthostatic blood problematic medical resident had falls hecheck the orthostatic blood problematic medical resident had falls hecheck the orthostatic blood problematic medical resident had falls hecheck the orthostatic blood problematic medical resident had falls hecheck the orthostatic blood problematic medical resident had falls hecheck the orthostatic blood problematic medical resident had falls hecheck the orthostatic blood problematic medical resident had falls hecheck the orthostatic blood problematic medical resident had falls hecheck the orthostatic blood problematic medical resident had falls hecheck the orthostatic blood problematic medical resident had falls hecheck the orthostatic blood problematic medical resident had fall blood problemat	atic hypotension associated ycardia (fast heart rate), and ncope (loss of consciousness ficient blood flow to the brain), e initial dose-titration period. may include: drowsiness, dedness, drooling, nausea, dness. 7 a.m. LPN-B stated they do essures on admission. LPN-A may do them if physician we an indication for it. 1 a.m. DON stated they do essures with initial admission sments. They do not routinely if ambulatory, or if not izziness. nitoring and Management indicated "consultant standing monitoring orders to appropriateness, cossible adverse the medications covered by the cost (CP) stated he was not allity blood pressure protocol ne facility to check the essures if resident was on ations. CP acknowledged if a e would expect the facility to ic blood pressures.	F 42			0/00/45
F 441 SS=D	483.65 INFECTION SPREAD, LINENS	I CONTROL, PREVENT	F 44	F1		9/22/15

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED	
		245395	B. WING _		08	/13/2015
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP COL 965 MCMILLAN STREET WORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 441	Infection Control Pr safe, sanitary and of to help prevent the of disease and infection. (a) Infection Control The facility must est Program under white (1) Investigates, control in the facility; (2) Decides what pushould be applied to (3) Maintains a reconstruction actions related to in (b) Preventing Spree (1) When the Infect determines that a reprevent the spread isolate the resident (2) The facility must communicable disection direct contact direct contact will tree (3) The facility must hands after each din hand washing is incorposessional practice (c) Linens Personnel must hand to the professional must hand to the profess	stablish and maintain an orgram designed to provide a comfortable environment and development and transmission ction. Il Program stablish an Infection Control ch it - introls, and prevents infections rocedures, such as isolation, or an individual resident; and ord of incidents and corrective infections. In add of Infection control chion Control Program esident needs isolation to of infection, the facility must characteristic and infected skin lesions with residents or their food, if ansmit the disease. It require staff to wash their rect resident contact for which dicated by accepted	F 44	.1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED	
		245395	B. WING		08/	08/13/2015	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		13/2015	
	OADS CARE CENTE			965 MCMILLAN STREET WORTHINGTON, MN 56187			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPOPER DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 441	by: Based on observareview, the facility precautions were prespiratory methiciaureus (MRSA) into the lungs, resistant 1 resident (R3). In glucometer was procleaning of glucomborne pathogens/if for 2 of 12 resident. Con 8/10/15, during for R3, at 5:18 p.m observed to enter gloves or face mast licensed practical isolation gown, fact R3 had a respirator standing in front of LPN-C entered the At 5:24 p.m. NAshe did not have to close to the reside cup of coffee. At 5:27 p.m. LPN staff was expected mask whenever in respiratory MRSA present during the staff are to gown, R3's respiratory coinfectious and still Vancomycin (antibut vancomycin (antibut vancomycin)	ation, interview and document failed to ensure universal practiced to prevent the spread addition (a serious infection of to most medications) for 1 of addition, facility did not ensure roperly cleaned (the proper neter reduces the risk of blood infections) between residents ts (R53, R56). If medication pass observation in nursing assistant (NA)-D was R3's room without gown, sk. Prior to entering R3's room, nurse (LPN)-C had put on an emask and gloves because bry infection. NA-D was R3 talking. NA-D left room as eroom. D was interviewed and stated of gown or glove if she was not int. She had just brought R3 a l-C was interviewed and stated to gown, glove and don a face R3's room because R3 had Registered nurse (RN)-E was interview and commented, "All mask and use gloves because andition. The MRSA is still has three more days of	F 44	It is the facility's policy to main infection control program that rexpectation to provide a safe, sand comfortable environment a prevent the transmission of disinfection. The Plan of Correction for residence the same as for all residents. Infection control policies have the reviewed for Universal/Standar Precautions and Isolation Precedence well as disinfection of glucome each resident use and transport contaminated items from room Policies/procedures are current accepted practice. The procedence been revised to include staff tratime a resident is placed on is precautions in addition to existing and annual training. A form hat developed and placed at both restations to be used for staff eduations. A physician, DON Charge Nurse will determine ty precautions. A physician, DON Charge Nurse will determine ty precautions to be used for indiversidents based on illness or discomplete this form which including information on type of precautions to the used for indiversidents based on illness or discomplete this form which including the precautions. Charge Nurse's responsibility to this information with staff mem	neets the anitary, and to help ease and lent R3 is leen dated autions as er between tation of s. and lation and initial is been for aution RCC or oe of ridual sease and les les ons to be oment en to the person alt is the person alt is the person and the person alt is the person and the person alt is the person and the person alt is the person alt is the person and the person and the person alt is the person and the person are person and the person and the person and the person and the person are person and the person are person and the person and the person are person are person are person and the person are person are person and the person are person are person are person and the person are person ar		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245395	B. WING			08/13/2015	
NAME OF	PROVIDER OR SUPPLIER			S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE		
CROSSF	ROADS CARE CENTE	R			65 MCMILLAN STREET VORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	interviewed and sta all the protective ges She stated she did had not gotten too of was between two to brought him some of coughing or wearing. On 8/12/15, at 10:0 observation, LPN-A floor at R3's feet put LPN-A was wearing semi-transparent so blue lid next to it. To between the square floor. LPN-A exited tub containing suppon the top of the tal without a barrier becontainer. R3 diagnosis including MRSA Pneumonia in which antibiotics R3 was severely correquired assistance and assistance with On 8/12/15, at 10:0 and verbalized "We and wear mask and MRSA. I normally displayed blood draw was not evening nurses wernormally take my with plastic tub) into the hallway. I took the verbalized in the hallway.	n the East unit. NA-D was sted she was supposed to wear arr: gown, mask and gloves. not wear any, because she close. She estimated that she of three feet from R3 when she coffee. She stated R3 was not g a mask. O a.m. during a random was observed sitting on the atting his white ankle socks on. If a gown, mask and gloves. A quare tub was on the floor with the tub did not have a barrier to tub and contaminated the R3's room and set the soiled olies for drawing blood down to be outside of R3's room tween the tabletop and set the soiled of the tub did not limited to bilateral (severe respiratory infection) were ordered and diabetes. On the soil of t	F	441	will have contact with the resident a resident's environment and to advis visitors and family members as wel will have contact with resident/residention after reviewing with the Charge Nurse to affirm understanding of is precautions specific to each residencharge Nurses will monitor and restaff as needed during periods of is precautions. Current and revised Infection Controlicies/procedures will be reviewed in-service to be held by 09/22/15. DON will complete random audits for adherence to infection controlicity for a period of four (4) week continue random audits thereafter a provide and document staff education needed until next QA. Results of auxill be reviewed by QA Committees determine if the plan of action is effor modifications need to be made. DON will complete random audits of when any resident is placed on isol precautions to ensure adherence to and procedures for specified isolation precautions. Results of audits will reviewed by QA Committee to dete the plan of action is effective or modifications need to be made. DON will complete random audits of audits and placed during the plan of action as needed during completed and docume education as needed	that lent's gn the e colation ont. educate colation or staff y as, and for as udits to ective of staff ation or policy on the staff etion of of the staff etion of of the staff etion et	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245395	B. WING		08/	13/2015	
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP 965 MCMILLAN STREET WORTHINGTON, MN 56187			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 441	Continued From pa		F 4				
	draw blood samples to resident, LPN-As lab blood requests	-		glucometer until next QA r of audits will reviewed by 0 to determine if the plan of effective or modifications r made.	QA Committee action is		
	director of nursing (residents who are of through report and are a definite cue to nurse. When a resi infections such as I precautions with staresident was] active to gown, glove and actively infectious." caddy on the floor of (warm pack) to con	8/13/15, at 11:11 a.m. the (DON) stated staff learn about on isolation precautions, the supplies outside the room ask for information from the dent was admitted with new MRSA we review the aff. DON stated, "I agree if [a ely systematic-(I) expect staff mask. I would gage (R3) as DON stated, "I don't like or her on floor. (I) expect it ne out in bag. By setting it of caddynow she just					
	(MRSA) in the Long 2009, noted the foll "Components of Sta The prevention prac- hand hygiene stand mask, eye protection appropriate to the a injection practices. gowns, and eyewest throughout the facil	t Staphylococcus aureus g-Term Care Facility dated owing: andard Precautions ctices include adherence to lards; use of gloves, gown,					
		ns also addresses oment or items in the resident le contaminated equipment in					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245395	B. WING			08/13/2015	
	PROVIDER OR SUPPLIER	R		965	REET ADDRESS, CITY, STATE, ZIP CODE S MCMILLAN STREET DRTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	agents. Proper han gloves and other approves and other approved and the responsibility of the solid reusable equation of the solid reusable equation of the solid reusable equation of the solid resident. (See the land of the solid resident of the s	and transmission of infectious adding includes the use of oppropriate PPE for direct ininated equipment. Heavily uipment must be immediately if appropriate, and removed to for thorough cleaning and lizing before use on another Environment and Equipment fection section.) " Ons was updated in the uideline for Isolation ude respiratory etiquette, a large the risk of respiratory included: care facility staff, residents, and sk of spread of respiratory althcare setting in instructions to residents and illy members or friends respiratory secretions h/nose with a tissue when large tisposal of used tissues, ks on the coughing person appropriate) er contact with respiratory sepiratory infections in delines for the environment	F 4	441			

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245395	B. WING _		80	/13/2015
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP 965 MCMILLAN STREET WORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 441	environmental staff component. Many including LTC facili environmental staff areas to provide cocleaning and disinfereautions should cleaning and disinfereautions should cleaning and disinfereautions. Areas effective cleaning anot limited to, bed at tables, bedside conthe resident's room the immediate area equipment that is not limited to the appropriate of the provide protocols. From the immediate area equipment cleaning environmental service delegated to the appropriate patient can disinfection of equipment to another to another protocols. From the facility protocols. From the facility provide precautions of equipment to another provide precautions, Catego 3/16/15. The policy 5. "In addition to precautions must be documented or sus microorganisms trained and staff and the protocol of the protocol	atient rooms by trained is an essential policy healthcare organizations, ties, assign dedicated it to targeted resident care possistency of appropriate ection procedures. Is who are in Contact Is be prioritized to frequent ection. Also, when a facility or acility are experiencing high or ates, it is warranted to go the frequency of cleaning and requiring more frequent, and disinfection include, but are rails, light switches, over-bed mmodes, bathroom fixtures in a of the resident, and any nulti-use between residents. If that is not performed by propriate healthcare staff per or instance, a facility cleaning licy or protocol will address the e staff responsibility for pment that may be taken from other." It a policy titled, Isolation pries of, dated reviewed	F 44	1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245395	B. WING			08/13/2015	
	PROVIDER OR SUPPLIER	R		9	TREET ADDRESS, CITY, STATE, ZIP CODE 65 MCMILLAN STREET VORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOL		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	coughing, sneezing procedures)c Masks "1. In addition to stamask when working Glucometer: On 8/12/15, at 7:45 perform a blood su the glucometer on barrier. When RN-Inurse's station and without barrier. RN Sani-wipe for 45 selancets, cotton ball: RN-D took the glucunit. RN-D told RN sanitized. RN-C we check on R56. RN-glucometer as the properly sanitized. one minute with Sablood sugar for R56 before contaminated. RN-D and RN-C we 8/12/15, at 10:00 a sanitizing a glucom nurses reviewed the sanitizing equipme and allow wipe to reminutes. During interview or DON stated staff we	enerated by the resident g, talking or the performance of andard precautions, wear a g within 3 feet of the resident." 5 a.m. RN-D was observed to gar check on R53. RN-D set the bedside table without a D was done he returned to the set the glucometer on desk-D wiped the glucometer with a econds and put it in caddy with a and blood glucose strips. Cometer and caddy to the East-C that the glucometer was ent to perform a blood sugar-C re-disinfected the glucometer had not been RN-C wiped glucometer for uni-wipe and then went do a surveyor stopped nurse ed glucometer was used. Bere interviewed together on and the sani-wipe instructions for the Sani-wipe instructions for the and verified it stated to clean emain in contact for two as 8/13/15, at 11:11 a.m. the test to clean glucometers by the each use with a dry time of 2	F 4	41			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245395	B. WING		08/	13/2015
	PROVIDER OR SUPPLIER OADS CARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 965 MCMILLAN STREET WORTHINGTON, MN 56187	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 492 SS=D	stated, "3b. in absence of hand thoroughly wet minutes to disinfect 4. Allow treated sur two (2) minutes. Us to assure continuous time. Allow to air dr. Policy labeled Clea Glucose Meters revito: "11. Use of disinfect germacides [sic] armanufacturers' inst specifications to avand visitors and to "Note: when selecti product, you will wan other words, you will wan other disinfect the item being clear considered killed. Short as one minute ten (10) minutes." 483.75(b) COMPLY FEDERAL/STATE/II The facility must op compliance with all local laws, regulation accepted profession that apply to professuch a facility.	neavy soil, take a clean wipe surface for a full two (2) t. face to remain wet for a full se additional wipe(s) if needed as two (2) minutes wet contact y." ning and Disinfecting Blood viewed 4/23/15, instructed staff tants, antiseptics and e in accordance with ructions and EPA or FDA label oid harm to staff, residents ensure effectiveness." ing a disinfecting cleaning ant to look art contact time. In ant to be aware of the length tant must be in contact with need for germ/bacteria to be some product it may be as e, another product it may be	F 4			9/14/15
	, -, - .					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		E SURVEY IPLETED
		245395	B. WING _		08/	13/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
CROSSR	OADS CARE CENTE	:R		965 MCMILLAN STREET		
				WORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 492	facility failed to ensure requested their bill intermediary for a facility and did a charged while the opending. Findings include: Facility said in the orequested a demark R34 was admitted SNF Determination 7/19/15, indicated fabill submitted to the Medicare decision, the intermediary for On 8/13/15, at 2:50 know which form to explained why we return to call if they family a copy and progive a copy to the family a copy and progive a copy to the family and progression of the sunderstand the form Medicare billing questions of the family of the family of the family and form that he cause the family then Stratis called the more information.	w and document review, the sure 1 of 1 resident (R34) who be submitted to the Medicare decision was not ensure R34 was not determination decision was entrance conference no one and bill. It to the facility on 5/28/15. R34's a on Continued Stay dated family desired to have R34's entermediary(Noridian) for a "I want my bill submitted to a Medicare decision." In p.m. RN-B stated, "I don't or give so I give them both. I made the decision and tell have any questions. I give the but mine in a binder. I do not billing office. I do not ms." RN-B referred the estions to be answered by the of the family or resident are ad information about appeals thad to start the process and the facility and ask the RCC for Then Stratis made the	F 49	It is the policy and procedure facility to submit demand bills intermediary/payor (National Services, Secure Blue or UC decision when requested by resident's Responsible Party. For R34: R34 is enrolled in SecureBlue Senior Health Option (MSHO which replaces Medicare Parresidents receiving MN Medic Assistance in nursing homes received skilled services from 7/31/15. Her stay for that pebilled to SecureBlue. On 7/2 facility issued a SNF Determic Continued Stay letter to the recare of her daughter stating to 7-29-15 we reviewed your medinformation and found that the furnished, skilled therapy ser longer qualified as covered undedicare beginning 8-1-15. is: Medicare covers medically skilled rehabilitation services needed on a daily basis. Whereapy from 6/1/15 to 7/31/1 information shows that the pit therapy services after that tim reasonable in relation to the comprovements in your conditions, since you do not need nursing on a daily basis and the part of the provements in your conditions, since you do not need nursing on a daily basis and the part of the part	e, a MN e) program t A for cal . R34 n 6/1/15 to riod was 9/15 the ination On esident in that "On edical e services vices, no nder The reason y necessary when ille you ohysical 5 medical ne are not expected on. In this skilled the therapy	
	more information. determination abou				the therapy reasonable	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245395	B. WING		08/	08/13/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	•	10,210	
CROSSE	OADS CARE CENTE	R	965 MCMILLAN STREET WORTHINGTON, MN 56187		37		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN	OF CORRECTION ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 492	Continued From page 42		 F4	92			
F 492	used to be the facil process but now th start of the appeal. billed her for her m was billed for the mappeal. The business office unable to explain w for a resident on M appeal to. On 8/13/15, at 3:19 stated facility follow should have submi	ity would start the appeal e family has to do the initial We pre-bill the month. We onthly liability August." R34 nonth(s) of the requested e manager and RN-B were that the appeal process was edicare or who to submit the p.m. the director of nurses as Medicare guidelines and tted the bill for review. the procedure for submission is requested, but not provided	F 4	7/31/15 is not covered The Resident Care Cocalled the resident's date to inform her of this dedocumented in the resercord "Daughter [name Medicare denial per plunderstanding Medicate to her for her signature that the daughter exprunderstanding and agriculity's decision. The the Verification of Recefaxed back to the facility acknowledges to not notice that the daughter mind and checked submitted to the internation Medicare decision." The facility will send a SecureBlue and will as before billing the reside Accounts Receivable I office manager) will coto see if she wants a respenddown paid for Accounts Receivable I office manager) will coto see if she wants a respenddown paid for Accounts Receivable I office manager) will coto see if she wants a respenddown paid for Accounts Receivable I office manager) will coto see if she wants a respenddown paid for Accounts Receivable I office manager) will coto see if she wants a respenddown paid for Accounts Receivable I office manager) will coto see if she wants a respenddown paid for Accounts Receivable I office manager) will coto see if she wants a respenddown paid for Accounts Receivable I office manager) will coto see if she wants a respenddown paid for Accounts Receivable I office manager) will coto see if she wants a respenddown paid for Accounts Receivable I office manager) will coto see if she wants a respenddown paid for Accounts Receivable I office manager) will coto see if she wants a respenddown paid for Accounts Receivable I office manager) will coto see if she wants a respenddown paid for Accounts Receivable I office manager) will coto see if she wants a respenddown paid for Accounts Receivable I office manager) will coto see if she wants a respenddown paid for Accounts Receivable I office manager) will coto see if she wants a respenddown paid for Accounts Receivable I office manager) will coto see if she wants a respenddown paid for Accounts Receivable I office manager) will coto see if she wants a respenddown paid for Accounts Receivable I office manager)	pordinator RN-B aughter on 7-29-15 ecision. This call is ident's medical ne] notified of none verb re denial form faxed e." RN-B recalls essed her reement with the edaughter signed eipt of Notice and ity on 7/29/15. The that facility staff did ghter had changed "A. I want my bill nediary for a demand bill to wait the decision ent further. The Manager (business ontact the daughter efund for the august, pending the e or if she would ceives the decision es:		
				The facility has review policy and procedure fresidents or their Responses	ed and revised its or notifying consible Parties nder their s and their rights to		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245395	B. WING		08/	13/2015
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 965 MCMILLAN STREET WORTHINGTON, MN 56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 492	Continued From pa	ge 43	F 4	forms to include current no for Medicare A, SecureBlue The RCCs and Accounts F Manager have been re-educorrect policy and procedur forms to use for each payon the Health Information Assistrack (log) and maintain a f Determination Notices, reversident/family member de provide copies to the Accommanger. The Accounts Remanger will review and logensure that demand bills a requested, notify the HIA with bill has been submitted and decision when received. The Administrator will audit maintained by the HIA more the policy/procedure is being Results of audits will be revert Quarterly QA meeting the plan of action is effective modifications need to be modifications need to be modifications.	e and UCare. Receivable receivable re and correct r. In the future, istant (HIA) will ile of all SNF receivable receivable resent when a demand dof the payor's rethe file/log of the file/log of the payor's rewed at the to determine if receivable receivable resent when a demand resent when a demand receivable resent when a demand receivable receivable receivable resent when a demand receivable receivable receivable receivable receivable receivable resent when receivable	

F5395024

PRINTED: 09/11/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 245395 08/11/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 965 MCMILLAN STREET **CROSSROADS CARE CENTER** WORTHINGTON, MN 56187 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) INITIAL COMMENTS K 000 K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on August 11, 2015. At the time of this survey. Crossroads Care Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or TITLE (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

09/07/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY MPLETED	
		245395	B. WING		08/	/11/2015
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 965 MCMILLAN STREET WORTHINGTON, MN 56187			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 000	By email to: Marian.Whitney@: <mailto:marian.wl 1.="" 1968="" 2.="" 3.="" <mailto:angela.ka="" a="" actual,="" addition="" and="" angela.kappenma="" auto="" basement,="" buildir="" care="" census<="" co="" con="" corprevent="" correct="" crossroads="" defice="" deficiency="" description="" determined="" fa="" facility="" fire="" following="" follows:="" for="" full="" fully="" had="" has="" height="" ii(111)="" in="" info="" is="" monitored="" mus="" name="" notification.="" of="" one-story="" open="" or="" oresponsible="" original="" p="" plan="" protect="" reoccurr="" sm="" spaces="" sprinkler="" td="" the="" to="" type="" was=""><td>state.mn.us nitney@state.mn.us> and ni@state.mn.us ppenman@state.mn.us> DRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done siency. roposed, completion date. or title of the person rection and monitoring to ence of the deficiency. Center was constructed as ng was constructed in 1953, is has a full basement, is fully cted and was determined to be struction; is one-story in height, has a ally fire sprinkler protected and be of Type II(111) construction. soke detection in the corridors of the corridors, which are matic fire department cility has a capacity of 50 beds of 40 at time of the survey. t 42 CFR, Subpart 483.70(a) is</td><td>K 00</td><td></td><td></td><td></td></mailto:marian.wl>	state.mn.us nitney@state.mn.us> and ni@state.mn.us ppenman@state.mn.us> DRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done siency. roposed, completion date. or title of the person rection and monitoring to ence of the deficiency. Center was constructed as ng was constructed in 1953, is has a full basement, is fully cted and was determined to be struction; is one-story in height, has a ally fire sprinkler protected and be of Type II(111) construction. soke detection in the corridors of the corridors, which are matic fire department cility has a capacity of 50 beds of 40 at time of the survey. t 42 CFR, Subpart 483.70(a) is	K 00			
K 029		AFETY CODE STANDARD	K 02	9		8/11/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01		COMPLETED	
		245395	B. WING		08/11/2015		
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP 965 MCMILLAN STREET WORTHINGTON, MN 56187	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CC X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
K 029 SS=D	fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro the approved autor option is used, the other spaces by sm doors. Doors are s field-applied protec	construction (with ¾ hour an approved automatic fire m in accordance with 8.4.1 tects hazardous areas. When natic fire extinguishing system areas are separated from noke resisting partitions and self-closing and non-rated or tive plates that do not exceed bottom of the door are	ΚO	29			
	Based on observatifacility failed to mai partitions and doors following requirements Section 19.3.2.1. Taffect 15 out of 50 medians include: On facility tour betwon 08/11/2015, observations of the following was found 1. The door to store ft.) has a kick down was propped open and the facility fails a store of the facility fails and the fails an	veen 9:15 AM and 11:00 AM ervation revealed that the		The kick down device was 8/11/15. Staff in dietary an housekeeping who use this were reminded that the doclosed at all times when not that doors to storage areas held open with any kind of except when staff are presseright or getting supplies the areas. The Maintenance Supervisoresponsible for correction at to prevent a reoccurrence deficiency and will report to supervisors of staff who us room (housekeeping and conterventions need to be tagent with the supervisors of staff who us room (housekeeping and conterventions need to be tagent with the supervisors of staff who us room (housekeeping and conterventions need to be tagent with the supervisors of staff who us room (housekeeping and conterventions need to be tagent with the supervisors of staff who us room (housekeeping and conterventions need to be tagent with the supervisors of staff who us room (housekeeping and conterventions need to be tagent with the supervisors of staff who us room (housekeeping and conterventions need to be tagent with the supervisors of staff who use room (housekeeping and conterventions need to be tagent with the supervisors of staff who use room (housekeeping and conterventions need to be tagent with the supervisors of staff who use room (housekeeping and conterventions need to be tagent with the supervisors of staff who use room (housekeeping and conterventions)	d s storage room or is to be kept of in use and s may not be door stop ent unloading to take to work for will be and monitoring of the to the te this storage lietary) if furthe		
		e Director (DV) at the time of		***************************************			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				(X3) DATE SURVEY COMPLETED	
		245395	B. WING			08/	/11/2015
	PROVIDER OR SUPPLIER	R	STREET ADDRESS, CITY, STATE, ZIP CODE 965 MCMILLAN STREET WORTHINGTON, MN 56187				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EA	ROVIDER'S PLAN OF CORRECTI CH CORRECTIVE ACTION SHOU SS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 076 K 076 SS=D	Medical gas storag protected in accord for Health Care Factaria, 2000 cu.ft. are end separation.	FETY CODE STANDARD e and administration areas are lance with NFPA 99, Standards	K C	š.			8/11/15
	Based on observal medical gas cylinder conformance with Management Area Chapter 4, Section practice could adversitors in the vicinit Room. FINDINGS INCLUE On facility tour betwoon 08/11/2015, obsempty oxygen cylin Oxygen Storage Rostored on the floor and were not secur tipping/falling. This arrangement was not securing the security of the security	veen 9:00 AM and 11:00 AM ervation revealed eleven (11) ders stored inside of the Main com. These cylinders were surface, in an upright position, red and located to prevent free-standing storage to in conformance with NFPA 4, Section 4-3.1.1.1 and		Director storerod cylinder staff we Nursing policy/proxygen The Director respons to preve deficien will audi	ector of Nursing will be sible for correction and moent a reoccurrence of the acy. The Maintenance Suit for compliance daily for sekly going forward to ass	ne oxygen y lursing ector of on and of onitoring pervisor 4 weeks,	

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NOWDER.	A. Buill	DING	01 - MAIN BUILDING 01		
		245395	B. WING			08/	11/2015
	PROVIDER OR SUPPLIER ROADS CARE CENTE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 965 MCMILLAN STREET WORTHINGTON, MN 56187				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	ACTION SHOULD BE TO THE APPROPRIATE	
K 076	•		K	076			
	This finding was co director (DV) at the	nfirmed with the facility time of discovery.					
							·



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted August 28, 2015

Ms. Barbara Atchison, Administrator Crossroads Care Center 965 McMillan Street Worthington, MN 56187

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5395025

Dear Ms. Atchison:

The above facility was surveyed on August 10, 2015 through August 13, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

Crossroads Care Center August 28, 2015 Page 2

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

Gloria Derfus, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900 gloria.derfus@state.mn.us Telephone: (651) 201-3792

Fax: (651) 215-9697

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gloria Derfus.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fishe Downing

Health Regulation Division Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

PRINTED: 09/14/2015 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00407	B. WING		08/14	3/2015
NAME OF I	PROVIDER OR SUPPLIER		DDECC CITY O	STATE, ZIP CODE	1 00/1	3/2013
		965 MCMI	LLAN STRE			
CROSSE	ROADS CARE CENTE	R WORTHIN	IGTON, MN	56187		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. In several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department witl	hearing on any assessments non-compliance with these tawritten request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are		Minnesota Department of Health i documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. I to	

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

Electronically Signed 09/07/15

STATE FORM 6899 WNSR11 If continuation sheet 1 of 35

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00407	B. WING		08/1	3/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
CROSSE	OADS CARE CENTE	R	LLAN STRE GTON, MN			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	CTION SHOULD BE CON	
2 000	REGULATORY OR LSC IDENTIFYING INFORMATION)		2 000	The assigned tag number appears far left column entitled "ID Prefix The state statute/rule out of complisted in the "Summary Statement Deficiencies" column and replaces Comply" portion of the correction of This column also includes the findiwhich are in violation of the state safter the statement, "This Rule is ras evidence by." Following the surfindings are the Suggested Method Correction and Time period for Co PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES/RULES.	Fag." iance is of the "To order. ings tatute not met veyors d of rrection. DING OF THIS	
21390	Subp. 4. Policies a control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans	O Subp. 4 A-I Infection Control and procedures. The infection ust include policies and provide for the following: based on systematic data a nosocomial infections in a detection, investigation, and sof infectious diseases; disprecautions systems to mission of infectious agents; ducation in infection	21390			9/3/15

Minnesota Department of Health

STATE FORM 6899 WNSR11 If continuation sheet 2 of 35

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00407	B. WING		08/1	3/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CROSSE	ROADS CARE CENTE	R	LLAN STRE GTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	E. a resident h immunization progredefined in part 465 procedures of resident he prevention and F. the development of the prevention and F. the development of the prevention and F. the development of the practices, including defined in part 465 G. a system for H. a system for products which affed disinfectants, antissincontinence product. I. methods for current standards of the prevent of the	ealth program including an am, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of olicies and infection control a tuberculosis program as 8.0815; rreviewing antibiotic use; rreview and evaluation of lect infection control, such as eptics, gloves, and	21390	Corrected		

Minnesota Department of Health

STATE FORM WNSR11 If continuation sheet 3 of 35

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00407	B. WING		08/1	3/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CROSSF	ROADS CARE CENTE	R	LLAN STRE IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21390	isolation gown, face R3 had a respirator standing in front of LPN-C entered the - At 5:24 p.m. NA-D she did not have to close to the resider cup of coffee At 5:27 p.m. LPN-staff was expected mask whenever in respiratory MRSA. present during the istaff are to gown, mR3's respiratory confectious and still had vancomycin (antibidated and the protective gets She stated she did had not gotten too was between two to brought him some of coughing or wearing. On 8/12/15, at 10:0 observation, LPN-A floor at R3's feet put LPN-A was wearing semi-transparent so blue lid next to it. The between the square floor. LPN-A exited tub containing suppon the top of the tal	Jourse (LPN)-C had put on an emask and gloves because by infection. NA-D was R3 talking. NA-D left room as room. O was interviewed and stated gown or glove if she was not not. She had just brought R3 a left was interviewed and stated to gown, glove and don a face R3's room because R3 had Registered nurse (RN)-E was interview and commented, "All hask and use gloves because notition. The MRSA is still has three more days of otic medication)." O was observed delivering on the East unit. NA-D was sted she was supposed to wear ear: gown, mask and gloves. Not wear any, because she close. She estimated that she of three feet from R3 when she coffee. She stated R3 was not	21390			

Minnesota Department of Health

STATE FORM 6899 WNSR11 If continuation sheet 4 of 35

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00407	B. WING		08/1	3/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CROSSI	ROADS CARE CENTE	·R	ILLAN STRE IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	age 4	21390			
	MRSA Pneumonia in which antibiotics R3 was severely corequired assistance and assistance with On 8/12/15, at 10:00 and verbalized "We and wear mask and MRSA. I normally oblood draw was not evening nurses we normally take my will plastic tub) into the hallway. I took the wit. I did put the control on the floor." When draw blood sample to resident, LPN-A lab blood requests During interview on director of nursing residents who are of through report and are a definite cue to nurse. When a resident was active to gown, glove and actively infectious." caddy on the floor of (warm pack) to control or the control of the co	22 a.m. LPN-A was interviewed be were told to always gown uped gloves. He has pneumonia do the labs on Tuesday but the tordered until yesterday. The re unable to draw his blood. I whole cart (pointed at the room. So it is not in the warm pack out but did not use tainer on the floor and I did sit in questioned if the container to is would be going from resident further stated, "I draw all of the in the building." 18/13/15, at 11:11 a.m. the (DON) stated staff learn about on isolation precautions, the supplies outside the room of ask for information from the ident was admitted with new MRSA we review the aff. DON stated, "I agree if [a lely systematic-(I) expect staff mask. I would gage (R3) as "DON stated, "I don't like for her on floor. (I) expect it me out in bag. By setting it of caddynow she just				

Minnesota Department of Health STATE FORM

WNSR11 If continuation sheet 5 of 35

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00407	B. WING		08/1	3/2015
	PROVIDER OR SUPPLIER	965 MCMI	DRESS, CITY, S LLAN STRE IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	Methicillin-Resistan (MRSA) in the Long 2009, noted the foll "Components of Sta The prevention practices appropriate to the ainjection practices. gowns, and eyewesthroughout the facil the "tools" needed to "tools" needed to "tools" needed to "tools" needed tools needed to "tools" needed tools needed	t Staphylococcus aureus g-Term Care Facility dated owing: andard Precautions ctices include adherence to lards; use of gloves, gown, on, or face shield as inticipated exposure; and safe PPE, including gloves, masks, ar, must be readily available ity to ensure that staff have to comply with Standard ans also addresses oment or items in the resident le contaminated equipment in at transmission of infectious dling includes the use of opropriate PPE for direct ninated equipment. Heavily ipment must be immediately if appropriate, and removed to for thorough cleaning and izing before use on another environment and Equipment fection section.) " Ins was updated in the ideline for Isolation ude respiratory etiquette, a g the risk of respiratory included: are facility staff, residents, and ask of spread of respiratory	21390			

Minnesota Department of Health

STATE FORM WNSR11 If continuation sheet 6 of 35

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(3) DATE SURVEY COMPLETED	
		00407	B. WING		08/1	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CROSSE	ROADS CARE CENTE	R	LLAN STRE			
040.15	CLIMMA DV CTA		IGTON, MN		ON	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 6	21390			
	coughing and prompt disposal of used tissues, using surgical masks on the coughing person when tolerated and appropriate) · Hand hygiene after contact with respiratory secretions · Maintaining a minimum of three-foot separation from persons with respiratory infections in common areas." In addition, the guidelines for the environment section revealed the following: "Environmental Cleaning and Disinfection Plan An environmental cleaning and disinfection plan includes policies or protocols that specify a defined schedule of environmental cleaning.					
	Daily cleaning of patient rooms by trained environmental staff is an essential policy component. Many healthcare organizations, including LTC facilities, assign dedicated environmental staff to targeted resident care areas to provide consistency of appropriate cleaning and disinfection procedures.					
	Rooms of residents who are in Contact Precautions should be prioritized to frequent cleaning and disinfection. Also, when a facility or specific units in a facility are experiencing high or increasing MRSA rates, it is warranted to consider increasing the frequency of cleaning and disinfection. Areas requiring more frequent, effective cleaning and disinfection include, but are not limited to, bed rails, light switches, over-bed tables, bedside commodes, bathroom fixtures in the resident's room, doorknobs, any equipment in the immediate area of the resident, and any equipment that is multi-use between residents. Equipment cleaning that is not performed by environmental services staff must be clearly					

Minnesota Department of Health

STATE FORM WNSR11 If continuation sheet 7 of 35

PRINTED: 09/14/2015 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00407	B. WING		08/1	3/2015
	NAME OF PROVIDER OR SUPPLIER CROSSROADS CARE CENTER STREET AE 965 MCM WORTHII					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	delegated to the ap facility protocols. For and disinfection pol specific patient care disinfection of equipone resident to ano. The facility provided Precautions, Categ 3/16/15. The policy 5. "In addition to Precautions must be documented or sus microorganisms trae (large-particle dropl size) that can be ge coughing, sneezing procedures) c Masks "1. In addition to stamask when working. Glucometer: On 8/12/15, at 7:45 perform a blood sughther glucometer on the barrier. When RN-Enurse's station and without barrier. RN-Sani-wipe for 45 selancets, cotton balls RN-D took the glucunit. RN-D told RN-sanitized. RN-C we check on R56. RN-glucometer as the groperly sanitized. For eminute with Sablood sugar for R56.	propriate healthcare staff per or instance, a facility cleaning icy or protocol will address the e staff responsibility for oment that may be taken from ther." d a policy titled, Isolation ories of, dated reviewed instructed staff to: Standard Precautions, Droplet e implemented for a resident pected to be infected with nsmitted by droplets ets [larger than 5 microns in merated by the resident, talking or the performance of andard precautions, wear a g within 3 feet of the resident." a.m. RN-D was observed to gar check on R53. RN-D set he bedside table without a D was done he returned to the set the glucometer on desk. D wiped the glucometer with a conds and put it in caddy with a and blood glucose strips. Ometer and caddy to the East C that the glucometer was nt to perform a blood sugar	21390			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY	
		00407	B. WING		08/1	3/2015
	PROVIDER OR SUPPLIER	965 MCMI	DRESS, CITY, S LLAN STRE IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21390	RN-D and RN-C we 8/12/15, at 10:00 a. sanitizing a glucom nurses reviewed the sanitizing equipmer and allow wipe to reminutes. During interview on DON stated staff we "Sanitizing between minutes." Super Sani Cloth G stated, "3b. in absence of h and thoroughly wet minutes to disinfect 4. Allow treated sur two (2) minutes. Us to assure continuou time. Allow to air dr Policy labeled Clea Glucose Meters revito: "11. Use of disinfect germacides [sic] armanufacturers' inst specifications to avand visitors and to "Note: when selecti product, you will wa other words, you wo of time the disinfect the item being clear considered killed. See the sanitizing and the sanitizing clear considered killed. See the sanitizing a glucom nurses reviewed to a sanitizing a glucom nurses reviewed the sanitizing a glu	ere interviewed together on m. They stated the policy for eter was 30 seconds. Both e Sani-wipe instructions for nt and verified it stated to clean emain in contact for two 8/13/15, at 11:11 a.m. the as to clean glucometers by a each use with a dry time of 2 duidelines for use dated 2014 eneavy soil, take a clean wipe surface for a full two (2) in face to remain wet for a full se additional wipe(s) if needed us two (2) minutes wet contact	21390			

Minnesota Department of Health

STATE FORM 6899 WNSR11 If continuation sheet 9 of 35

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						
		00407	B. WING		08/1	3/2015
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S LLAN STRE	STATE, ZIP CODE		
CROSSF	OADS CARE CENTE	R	IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 9	21390			
21426	The director of nurse the policies and process and provide education to could develop a moongoing compliance Qualify Assurance (CTIME PERIOD FOR (21) days. MN St. Statute 144.	R CORRECTION: Twenty one A.04 Subd. 3 Tuberculosis	21426			9/3/15
	Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.					

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00407	B. WING		08/1	3/2015
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	00/1	0/2013
CROSSE	OADS CARE CENTE	R	LLAN STRE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From page 10		21426			
	by: Based on interview facility failed to ens R56, R57) and 2 of had Tuberculin Ski interpretation and T screening per TB S Findings included: R53 was admitted t medical record reve Screening Tool for addition it was reve step TST on 7/24/1 "Negative" interpret induration in millimed R56 was admitted t medical record indiof her TST on 7/23/as 0 mm with a "Negative" interpret induration in millimed R56 was admitted to the total record individual record indivi	and document review, the ure 3 of 3 residents (R53, 5 recently hired employees in Test (TST) induration Tuberculosis (TB) symptom creening State Regulations. To the facility on 7/20/15. The ealed the Baseline TB Residents on the same day. In aled R53 had received the first 5, and results were read as ration on 7/27/15, however no eter (mm) was indicated. To the facility on 7/22/15. R56's coted he received the first step (15, and the results were read agative" interpretation of R56 then received the		Corrected		
	reading on 7/25/15. R56 then received the second step TST on 8/7/15, results were read on 8/9/15, as 0 mm with a negative interpretation however review of the TB symptom screening form revealed it was not dated					
	form revealed it was not dated. R57 was admitted to the facility on 7/24/15. The medical record revealed the Baseline TB Screening Tool for Residents on the same day. In addition it was revealed R53 had received the first step TST on 7/24/15, and results were read as 0 mm with a "Negative" interpretation of reading on 7/26/15. Additionally the medical record revealed R57 then received the second step TST on 8/8/15, results were read on 8/10/15, with a negative interpretation however no induration was indicated.					

6899

Minnesota Department of Health STATE FORM

WNSR11 If continuation sheet 11 of 35

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00407	B. WING		08/1	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	_	
CROSSI	ROADS CARE CENTE	R	LLAN STRE IGTON, MN			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
21426	a hire date of 6/22/ Employee Tubercul it was revealed the and was blank yet a had received the fir results were read a interpretation of reasecond step TST of 8/9/15, as 0 mm with A review of mainter a hire date of 5/5/18 symptom screening completed on 5/4/1 revealed M-A had resulted may be a more read on 5/4/15, and resulted may be a more read on 5/21/1 interpretation hower indicated. On 8/11/15, at 1:53 were supposed to it assessment had be nurse (RN)-A stated on 8/13/15, at 1:03 first step TST had resulted on 8/13/15, at 1:06 (DON) acknowledges should have both the interpretation. In ad symptom screening completed for the ewere supposed to be a supposed to	assistant (NA)-C file revealed 15. During review of the osis symptom screening form form had not been complete at the back of it revealed NA-C st step TST on 6/22/15, and so mm with a "Negative" iding on 6/24/15, and the n 8/7/15, results were read on the an egative interpretation. It ance staff (M)-A file revealed 5. The Employee Tuberculosis form indicated it had been 5. During further review it was eceived the first step TST on were read as 0 mm with a ation of reading on 5/6/15, p TST on 5/18/15, results 15, with a "negative" ver no induration was p.m. when asked if nurses indicate the date when sen completed registered in absolutely. " 1 a.m. RN-B verified R53's no induration documented. p.m. the director of nursing ed the TST reading for R57	21426			

Minnesota Department of Health

STATE FORM 6899 WNSR11 If continuation sheet 12 of 35

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		X3) DATE SURVEY COMPLETED	
		00407	B. WING		08/1	3/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
CROSSE	OADS CARE CENTE	R	LLAN STRE				
040.15	CUINANA DV CTA	TEMENT OF DEFICIENCIES	IGTON, MN		ON	0/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	SHOULD BE COMPLETE		
21426	6 Continued From page 12		21426				
		form had not been completed pp TST lacked the induration.					
	Regulation for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, Screening Health Care Workers (HCW's) directed "An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative Interferon-Gamma Release Assays [IGRA] (blood test) or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients Serial TB screening Serial TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a one-step TST or single IGRA"						
	director of nursing of	THOD OF CORRECTION: The could inservice staff control on the protocol from					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One					
21530	MN Rule 4658.1310	O A.B.C Drug Regimen Review	21530			9/3/15	
	reviewed at least m currently licensed b This review must be	en of each resident must be conthly by a pharmacist by the Board of Pharmacy. The done in accordance with State Operations Manual,					

Minnesota Department of Health

STATE FORM 6899 WNSR11 If continuation sheet 13 of 35

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			
		00407	B. WING		08/1	3/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CROSSF	ROADS CARE CENTE	R	ILLAN STRE IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21530	Surveyor Procedure Requirements in Lot the Department of Health Care Finance This standard is in available through the system. It is not sue B. The pharma irregularities to the and the attending pure must be acted upon physician visit, or support and the sign of nursing services C. If the attend with the pharmacist not provide adequate pharmacist believe being adversely after the matter to the if the medical direct physician. If the medical direct physician does not must be referred for assessment and as by part 4658.0070. The medical direct must refer the matter to the physician does not must be referred for assessment and as by part 4658.0070. The medical direct must refer the matter than assessment and as the system of the physician does not must be referred for assessment and as the physicia	es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, sing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan abject to frequent change. It is ne Minitex interlibrary loan abject to frequent change. It is ne Minitex interlibrary loan abject to frequent change. It is ne Minitex interlibrary loan abject to frequent change. It is not met at the ingent of the next ooner, if indicated by the arposes of this part, "acted occeptance or rejection of the ing or initialing by the director and the attending physician. It is physician does not concurt the resident's quality of life is ected, the pharmacist must the medical director for review tor is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter or review to the quality essurance committee required. If the attending physician is or, the consulting pharmacist for the consulting pharmacist for directly to the quality essurance committee.	21530	Corrected		
		consultant pharmacist failed g for blood pressures for 3 of				

Minnesota Department of Health

STATE FORM 6899 WNSR11 If continuation sheet 14 of 35

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00407		B. WING		08/1	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CROSSF	ROADS CARE CENTE	R	LLAN STRE IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	0 Continued From page 14		21530			
	5 residents (R49, R2, R20) who were on antipsychotic medications reviewed for unnecessary medications.					
	Findings include:					
	R49 was observed on 8/12/15, at 7:27 a.m. asleep on the recliner in the common area -At 8:30 a.m. R49 was observed seated at the dining room tableAt 9:45 a.m. R49 was observed ambulate down the hallway from her room to the common area with a staff person and a transfer belt around her waist and was noted with unsteady gait. Staff then assisted her to the reclinerAt 10:13 a.m. R49 was again observed ambulating independently gait unsteady and was redirected to sit. R49 was noted to have a flat affect.					
	behavioral disturba disorder obtained fi dated 6/2/15. In add revealed an admiss Minimum Data Set R49 received both	dications daily and was noted				
	6/14/15, indicated If wandered, had imp an antidepressant. CAA dated 6/14/15 antidepressant and The CAA indicated psychotropic drug sto monitor for response.	a Assessment (CAA) dated R49 was at risk for falls, aired balance/gait and used Psychotropic drug medication, indicated R49 used antipsychotic medications. R49 was at risk for side effects. CAA directed staff onse and any changes in and mental status however did				

Minnesota Department of Health

STATE FORM 6899 WNSR11 If continuation sheet 15 of 35

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00407	B. WING		08/1	3/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
CROSSF	CROSSROADS CARE CENTER 965 MC WORTH					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	not indicate address monitor for orthostal R49's psychotropic 6/21/15, indicated F effects related to us plan directed to mo effects, orthostatic's movement disorder R49's Physician's C revealed the followi -Depakote (mood s milligrams (mg) by (TID) for demential relationship of the medical for daily for dysthymic relationship of the medical forms with behalf and the medical for the floor sustained however had not been done incident. During further docu the Consultant pharmonthly review had with other previous 6/2/15, and had been clinical problems were usually done for the floor sustained however had not been done incident. On 8/12/15, at 2:25 BP's were usually done for the floor sustained however had not been done incident.	drug use care plan dated and was at risk for adverse se of medications. The care nitor R49 for potential side se per protocol and monitor DISCUS per policy. Orders Sheet dated 7/22/15, and orders: tabilizer) sprinkles 250 mouth (PO) three times daily with behavioral disturbance. The research was always and the protocol and monitor of DISCUS per policy. Orders Sheet dated 7/22/15, and orders: tabilizer) sprinkles 250 mouth (PO) three times daily with behavioral disturbance. The protocol and provided and pr	21530			
		them. RN-A verified d not been done on admission				

Minnesota Department of Health

STATE FORM WNSR11 If continuation sheet 16 of 35

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00407	B. WING	·····	08/1	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	-	
CROSSF	ROADS CARE CENTE	R	ILLAN STREI NGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21530	6/1/15, after she we evaluation. RN-A fu some vital signs at not been re-attempt On 8/13/15, at 11:4 consultant pharmac familiar with the fac pressures (BP's) pr facility to check the was on problematic acknowledged if a rexpect the facility to CP indicated he wo check the orthostatic was on atypical anti On 8/13/15, at 12:1 facility protocol was orthostatic blood pr (DON) stated for all psychotropic medic falls they were supp would be deferred in ambulating, did not reposition themselves a resident was initial orthostatic BP's we times it would be direct and the control of the proposition of the position themselves are sident was initial orthostatic BP's we times it would be direct and the control of p.m. DON to obtain orthostatic were admitted due to the control of the proposition of the propositio	ent through the admit rther stated R49 had refused the time of admission but had ted. O a.m. via telephone the sist (CP) stated he was not ility orthostatic blood otocol and would expect the orthostatic BP's if resident medications. CP resident was had falls would ocheck the orthostatic BP's. uld not expect the facility to ic BP's for R49 because she ipsychotic medications. 3 p.m. when asked what the for monitoring/checking residents who were on ations and were at risk for cosed to be done monthly but fa resident was not transfer self or did not res. DON further stated when ally admitted to the facility re supposed to be done but at fficult to obtain them. Stated although it was difficult to BP's initially when residents to adjustment and behaviors the nurses should have	21530			
	was admitted to the	dated 5/11/15, indicated R2 facility on 2/2/09. Admission depression, psychosis,				

Minnesota Department of Health

STATE FORM WNSR11 If continuation sheet 17 of 35

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
	00407		B. WING		08/1	3/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•		
CROSSROADS CARE CENTER			LLAN STRE GTON, MN				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
21530	Continued From page 17		21530				
	schizoaffective disorder, anxiety, heart failure, COPD, and CHF.						
	The MDS dated 8/13/15, indicated R2 was cognitively intact. R2 required setup help with bed mobility, transfers, toilet use, and two person assist with dressing.						
	The CAA dated 8/13/15, indicated R2 did not exhibit behaviors.						
	The Care Plan dated 8/23/12, indicated R2 had psychosis depressed mood related to history of long term schizoaffective disorder as evidenced by poor grooming.						
	Physician orders da 15 mg at bedtime.	ated 8/11/15, included Zyprexa					
	A review of the medical record from 8/13/15, revealed the medical record lacked documentation of orthostatic blood pressure (BPs) monthly for the antipsychotic medication Zyprexa.						
	The manufacturers package insert for Zyprexa (olanzapine) indicated patients would be at risk for orthostatic hypotension (a fall in blood pressure when changing positions) olanzapine may induce orthostatic hypotension associated with dizziness, tachycardia (fast heart rate), bradycardia (slow heart rate), and in some patients syncope (a temporary loss of consciousness and posture), especially in patients with known heart disease or with other medications known to cause hypotension." Other side effects may include: drowsiness, dizziness, lightheadedness, stomach upset, dry mouth, constipation, increased appetite, or weight gain.						

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	00407		B. WING		08/13/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
CROSSE	ROADS CARE CENTE	R	LLAN STRE GTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21530	On 8/13/15, at 10:5 (LPN)-B stated they pressures on admis they may do them in have an indication of the management of t	7 a.m. licensed practical nurse of do orthostatic blood esion. LPN-A further stated of physician orders it or they for it. 1 a.m. DON stated they do essures with initial admission ements. They do not routinely if ambulatory, or if not izziness. 0 a.m. via telephone the coist (CP) stated he was not efficility blood pressure protocol ne facility to check the essures if resident was on ations. CP acknowledged if a ele would expect the facility to ic blood pressures. S dated 7/17/15, indicated to the facility on 6/8/10. es included hypertension, hizophrenia. 3/15, indicated R20 required with bed mobility, transfers,	21530			

Minnesota Department of Health

STATE FORM 6899 WNSR11 If continuation sheet 19 of 35

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00407	B. WING		08/13/2015	
	NAME OF PROVIDER OR SUPPLIER CROSSROADS CARE CENTER 965 MCM WORTH					
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	Continued From page 19		21530			
	Physician orders dated 8/12/15, included Risperdal 1.0 milligrams (mg) at bedtime.					
	A review of the medical record from 8/13/15, revealed the medical record lacked documentation of orthostatic blood pressure (BPs) monthly for the antipsychotic medication Risperdal.					
	The manufacturer's package insert for Risperdal (risperidone) indicated patients would be at risk for orthostatic hypotension (a fall in blood pressure when changing positions) risperidone may induce orthostatic hypotension associated with dizziness, tachycardia (fast heart rate), and is some patients syncope (loss of consciousness resulting from insufficient blood flow to the brain), especially during the initial dose-titration period. Other side effects may include: drowsiness, dizziness, lightheadedness, drooling, nausea, weight gain, or tiredness.					
	orthostatic blood pr further stated they	7 a.m. LPN-B stated they do essures on admission. LPN-A may do them if physician re an indication for it.				
	orthostatic blood pr and with fall assess	1 a.m. DON stated they do essures with initial admission ments. They do not routinely if ambulatory, or if not izziness.				
	policy dated 4/1/15, pharmacist use the assist in assessing effectiveness, and p					

Minnesota Department of Health

STATE FORM WNSR11 If continuation sheet 20 of 35

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED	
		00407	B. WING		08/1	3/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CROSSF	OADS CARE CENTE	R	ILLAN STRE IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21530	consultant pharmace familiar with the face and would expect the orthostatic blood preproblematic medical resident had falls he check the orthostate SUGGESTED MET. The Director of Nurwork with the medical pharmacist to ensured medication irregulate the staff were educated medication irregulated could randomly audicadequate monitoring documentation was	0 a.m. via telephone the cist (CP) stated he was not illity blood pressure protocol ne facility to check the essures if resident was on ations. CP acknowledged if a ewould expect the facility to ic blood pressures. THOD OF CORRECTION: sing (DON) or desigee could cal director and consultant re to inform the facilty rities. The DON could ensure ated on the importance of rities. The DON or designee dit resident records to ensure g, parameters and	21530			
21540	Usage; Monitoring Subp. 2. Monitoring monitor each reside unnecessary drug u home's policies and pharmacist must re resident's attending physician does not home's recommend adequate justificatio believes the residen	g. A nursing home must ent's drug regimen for usage, based on the nursing diprocedures, and the port any irregularity to the physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist not's quality of life is being the pharmacist must refer the	21540			9/3/15

Minnesota Department of Health

STATE FORM 6899 WNSR11 If continuation sheet 21 of 35

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COMF			SURVEY LETED	
		00407	B. WING		08/1	3/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
		965 MCMI	ILLAN STRE			
CROSSF	ROADS CARE CENTE	K WORTHIN	IGTON, MN	56187		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	matter to the medicial medical director is in the medical director is in the medical director physician does not the order and if the change the order, the review to the Qualit (QAA) committee restricted the attending physisthe consulting pharmal directly to the QAA. This MN Requirements by: Based on observation review the facility factorial (R49, R2, R20) had psychotropic medicial Findings include: R49 was observed asleep on the reclining-At 8:30 a.m. R49 with dining room tableAt 9:45 a.m. R49 with the hallway from hewith a staff person awaist and was noted then assisted her to the control of t	all director for review if the not the attending physician. If r determines that the attending have adequate justification for attending physician does not he matter must be referred for y Assurance and Assessment equired by part 4658.0070. If ician is the medical director, macist shall refer the matter ent is not met as evidenced on, interview and document filled to ensure 3 of 6 residents adequate monitoring for ations. On 8/12/15, at 7:27 a.m. ther in the common area was observed seated at the exact observed ambulate down for room to the common area and a transfer belt around her d with unsteady gait. Staff to the recliner. Was again observed andently gait unsteady and was to was noted to have a flat cluded dementia with noe, insomnia and dysthymic form admission face sheet	21540	Corrected		
	behavioral disturbated disorder obtained fr	nce, insomnia and dysthymic				

Minnesota Department of Health

STATE FORM WNSR11 If continuation sheet 22 of 35

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00407	B. WING		08/1	3/2015
NAME OF PROVIDER OR SUPPLIER			TATE, ZIP CODE		
CROSSROADS CARE CENTER		ILLAN STRE IGTON, MN			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
MDS dated 6/8/15, indicated antipsychotic and anticipated and was noted Research 14/15, indicated R49 wandered, had impaired an antidepressant. Psychotropic drug side to monitor for responsive resident physical and into indicate address with monitor for orthostatic R49's psychotropic drug side to monitor for orthostatic R49's psychotropic drug side to monitor for orthostatic R49's psychotropic drug feets related to use of plan directed to monitor effects, orthostatic's permovement disorder DI R49's Physician's Order revealed the following Depakote (mood stab milligrams (mg) by mo (TID) for dementia with Remeron (antidepressidaily for dysthymic disorder DI Risperdal 0.25 mg PO dementia with behavior A review of the medical revealed rev	n date of 6/1/15. Admission dicated R49 received both depressant medications R49 had behaviors. Assessment (CAA) dated 9 was at risk for falls, red balance/gait and used sychotropic drug medication idicated R49 used ntipsychotic medications. R49 was at risk for reflects. CAA directed staff record and monitor reflects. The care of medications. The care of R49 for potential side reflects. Per policy. Reflects Sheet dated 7/22/15, recorders: Sprinkles 250 reflects. Can reflect reflects and record from 6/1/15, record lacked restatic blood pressure	21540	DELIGITION)		

Minnesota Department of Health

STATE FORM 6899 WNSR11 If continuation sheet 23 of 35

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING.			
		00407	B. WING		08/1	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CROSSF	ROADS CARE CENTE	R	ILLAN STRE IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21540	Continued From pa	nge 23	21540			
		orthostatic blood pressures either at the time of the				
	BP's were usually of doctor had ordered orthostatic B/P's hat 6/1/15, after she we evaluation. RN-A furth some vital signs at not been re-attemption.					
	facility protocol was orthostatic blood presidents who were and were at risk for be done monthly but resident was not ar or did not reposition stated when a resident was not at the facility orthostatic done but at times it them. -At 1:06 p.m. DON to obtain orthostatic were admitted due she acknowledged attempted later to ostated the resident responsible for mal assessment were at CP should have cat assessment had be	3 p.m. when asked what the stor monitoring/checking ressures DON stated for all et on psychotropic medications realls they were supposed to at would be deferred if a mbulating, did not transfer self in themselves. DON further dent was initially admitted to tic BP's were supposed to be would be difficult to obtain stated although it was difficult to BP's initially when residents to adjustment and behaviors the nurses should have obtain the BP's. DON further care coordinators were king sure the DISCUS accurately completed and the ught it but thought the gen done prior to the current and switched pharmacists.				
		dated 5/11/15, indicated R2 a facility on 2/2/09. Admission				

Minnesota Department of Health

STATE FORM 6899 WNSR11 If continuation sheet 24 of 35

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00407	B. WING		08/1	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CROSSF	ROADS CARE CENTE	R	ILLAN STRE NGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 24	21540			
	diagnoses included depression, psychosis, schizoaffective disorder, anxiety, heart failure, COPD, and CHF.					
	The Minimum Data Set (MDS) dated 8/13/15, indicated R2 was cognitively intact. R2 required setup help with bed mobility, transfers, toilet use, and two person assist with dressing. R2's CAA dated 8/13/15, indicated R2 did not exhibit behaviors.					
	R2's care plan dated 8/23/12, indicated R2 had psychosis, had depressed mood related to history of long term schizoaffective disorder as evidenced by poor grooming.					
		rs dated 8/11/15, included otic) 15 mg at bedtime.				
	A review of the medical record from 8/13/15, revealed the medical record lacked documentation of orthostatic BPs monthly for the antipsychotic medication Zyprexa.					
	(olanzapine) indicate for orthostatic hypotopressure when chain may induce orthostatic with dizziness, tach bradycardia (slow high patients syncope (a consciousness and patients with known medications known side effects may inclightheadedness, st	package insert for Zyprexa ed patients would be at risk tension (a fall in blood nging positions) olanzapine atic hypotension associated ycardia (fast heart rate), eart rate), and in some temporary loss of posture), especially in heart disease or with other to cause hypotension. Other clude: drowsiness, dizziness, omach upset, dry mouth, sed appetite, or weight gain.				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00407	B. WING		08/1	3/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CROSSF	ROADS CARE CENTE	R	ILLAN STRE IGTON, MN			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21540	Continued From page 25		21540			
	R20 was admitted to Admission diagnost depression, and so R20's quarterly Min 8/13/15, indicated Fantipsychotic and a daily and was noted R20's CAA dated 8 exhibit behaviors. In 8/13/15, indicated Fas evidenced by disparticipating with care	imum Data Set (MDS) dated R20 received both antidepressant medications d R20 refused cares. /13/15, indicated R20 did not a addition care Plan dated R20 had history of depression splay of little interest in ares, therapy, activities, onnect. R20 was resistive to ow staff to provide				
		ders dated 8/12/15, indicated erdal 1.0 mg at bedtime.				
	A review of the medical record from 8/13/15, revealed the medical record lacked documentation of orthostatic BPs monthly for the antipsychotic medication Risperdal.					
	(risperidone) indica for orthostatic hypo pressure when cha may induce orthost with dizziness, tach is some patients sy resulting from insuf especially during th Other side effects r	s package insert for Risperdal ted patients would be at risk tension (a fall in blood nging positions) risperidone atic hypotension associated lycardia (fast heart rate), and incope (loss of consciousness ficient blood flow to the brain), e initial dose-titration period. may include: drowsiness, dedness, drooling, nausea, dness.				

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 26 of 35 WNSR11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00407	B. WING		08/13/2015	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CROSSF	CROSSROADS CARE CENTER 965 MCM WORTHI					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	ECTIVE ACTION SHOULD BE COMPLE ENCED TO THE APPROPRIATE DATE	
21540	Continued From page 26		21540			
	(LPN)-B stated they pressures on admis they may do them is have an indication for the state of t	1 a.m. DON stated they do essures with initial admission ments. They do not routinely if ambulatory, or if not izziness. nitoring and Management indicated"consultant standing monitoring orders to appropriateness,				
	The Director of Nur work with the medic pharmacist to ensu for appropriate inter parameters for use staff were educated monitoring for unne DON or designee of records to ensure a parameters and do	sing (DON) or desigee could cal director and consultant re medications were reviewed rentions, monitoring and . The DON could ensure the don the importance of cessary medications. The ould randomly audit resident adequate monitoring, cumentation was in place.				
21620	MN Rule 4658.1345	5 Labeling of Drugs	21620			9/3/15

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00407	B. WING		08/1	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CROSSE	ROADS CARE CENTE	R	LLAN STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21620	•	ursing home must be labeled	21620			
	by: Citation Text for Tag Jares, Magdalene	ent is not met as evidenced g 0425, Regulation FF09 on, interview and document		Corrected		
	review, the facility famedications were sunits. In addition fai	ailed to ensure expired tored in 2 of 2 medication led to ensure medications with re dated when opened.				
	medication tour to t licensed practical n nurse (RN)-B who p	2 a.m. completed the he medication cart with urse (LPN)-B and registered provided access to the cart following were identified:				
	analgesic) 81 millig expiration date 7/15 -Enteric coated Asp house stock bottle v-Benadryl (anti-hista with 22 left with exp-Serevent Diskus (kmicrograms (mcg) to opened. LPN-B ack been dated when or-Multi-vitamin with rexpiration date 10/1-Advair Diskus (bre	wirin 81 mg analgesic 1000 with expiration date 3/15. amine) 25 mg 24 tablet boxes wiration date 1/15. breathing medication) 50 for R2 not dated when knowledged should that have pened. minerals 100 tablets with				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00407	B. WING		08/1	3/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CROSSF	ROADS CARE CENTE	R	ILLAN STRE IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TION SHOULD BE COMPLETI THE APPROPRIATE DATE	
21620	0 Continued From page 28		21620			
	dated when opened received the inhale expired medication to be dated when of medications were rethe medication card was responsible for On 8/13/15, at 10:5 (DON) stated inhalm when opened and took at the labels a not supposed to be was responsible for	not supposed to be stored in t. LPN-B stated the night nurse				
	The Servent Diskus package insert information from GlaxoSmithKline LLC dated 2/15, directed the following information on how to store the medication. "• Store SEREVENT DISKUS in the unopened foil pouch and only open when ready for use. • Safely throw away SEREVENT DISKUS in the trash 6 weeks after you open the foil pouch or when the counter reads 0, whichever comes first." The Advair Diskus package insert information from GlaxoSmithKline LLC dated 4/14, directed the following information on how to store the medication. "• Store ADVAIR DISKUS in the unopened foil pouch and only open when ready for use. • Safely throw away ADVAIR DISKUS in the trash					
		open the foil pouch or when the hichever comes first."				

6899

Minnesota Department of Health STATE FORM

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00407	B. WING		08/13/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	1 00/1	0,1010
CROSSF	ROADS CARE CENTE	R	LLAN STRE			
			IGTON, MN			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	SHOULD BE COMPLETE	
21620	Continued From page 29		21620			
	tour as completed value following were iden medications would destroyedMulti-Vitamin with unopened with expirations and carbonate for the following series of the following	6 a.m. the medication storage with RN- E. During the tour the tified and RN-E stated expired be sent to the pharmacy or mineral 100 tablet bottle tration date 10/14. The (promote bone growth) 1250 blets with expiration date 7/15.				
	Page, Lou Anne Medication storage on the long term care unit was conducted with LPN-B on 8/13/15, at 1:15 p.m. and the following discrepancies were noted and LPN-B concurred:					
	treat various skin or expired on 6/15 and McKesson Vit A at the month was not - ASA 81 mg 1000 expired 3/15 ASA 81 mg OTC 8 - Daily Multivitamine expired 10/14 Solution of Hydrogagent) 3% expired - Migraine Formula 24 capsules unoper - One Daily Multivita unopened, expired - Levemir Insulin (mblood sugar) disper	tablets over the counter (OTC) 500 tablets expired 7/15. s with Minerals 100 tablets gen Peroxide (germicidal 7/15, for two bottles. (medication for headaches), ned box expired 11/14. amin with Minerals 100 tablets,				
	The Levemir Insulir	n package insert information				

Minnesota Department of Health

STATE FORM 6899 WNSR11 If continuation sheet 30 of 35

PRINTED: 09/14/2015 FORM APPROVED

Minnesota Department of Health

STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00407	B. WING		00/4	2/2015
		00407	00/10/2010			
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CROSSF	ROADS CARE CENTE	2	LLAN STRE IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21620	Continued From pa	Continued From page 30				
	following information medication. "Vials: After initial use, vial refrigerator, never in not possible, the inunrefrigerated at ro (86°F) as long as it and away from directevemilar vials sho initial use. Unrefrige be discarded 42 da of the refrigerator. LEVEMIR FlexTouck After initial use, the NOT be stored in a stored with the need (in use) LEVEMIR FlexTouck After initial use, the NOT be stored in a stored with the need (in use) LEVEMIR FlexTouck After initial use, the NOT be stored in a stored with the need (in use) LEVEMIR FlexTouck After initial use, the NOT be stored in a stored with the need (in use) LEVEMIR FlexTouck After initial use, the NOT be stored in a stored with the need (in use) LEVEMIR FlexTouck After initial use, the NOT be stored in a stored with the need (in use) LEVEMIR FlexTouck After initial use, the NOT be stored in a stored with the need (in use) LEVEMIR FlexTouck After initial use, the NOT be stored in a stored with the need (in use) LEVEMIR FlexTouck After initial use, the NOT be stored in a stored with the need (in use) LEVEMIR FlexTouck After initial use, the NOT be stored in a stored with the need (in use) LEVEMIR FlexTouck After initial use, the NOT be stored in a stored with the need (in use) LEVEMIR FlexTouck After initial use, the NOT be stored in a stored in a stored with the need (in use) LEVEMIR FlexTouck After initial use, the NOT be stored in a stored in a stored with the need (in use) LEVEMIR FlexTouck After initial use, the NOT be stored in a stored in	LEVEMIR FlexTouch must refrigerator and must NOT be dle in place. Keep the opened flexTouch away from direct om temperature, below 30 °C ed LEVEMIR FlexTouch d 42 days after they are first gerator." ge of Medications policy tinued, outdated, or ations are available for use in medications are destroyed" HOD OF CORRECTION: The tor of nursing (DON) and dist could review and revise ures for proper storage of a staff could be educated as portance of labeling ly and discarding expired ON or designee, along with all audit medications on a				

Minnesota Department of Health

TIME PERIOD FOR CORRECTION: Twenty one

STATE FORM 6899 WNSR11 If continuation sheet 31 of 35

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00407	B. WING		08/1	3/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CROSSF	ROADS CARE CENTER	R	LLAN STRE IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
21620	Continued From pa	ge 31	21620			
	(21) days.					
21995	MN St. Statute 626. Maltreatment of Vul	557 Subd. 4a Reporting - nerable Adults	21995			9/3/15
	(a) Each facility shat ongoing written pro- applicable licensing of suspected maltre- facility has an interri mandated reporter requirements of this internally. However responsible for com- reporting requirements					
	by: Based on interviews facility failed to imm administrator and S thoroughly investiga	tate agency (SA) and ate an allegation of an injury of 4 residents (R33) reviewed		Corrected		
	Findings include:					
	4/16/08, informed s "Investigation: All in changes of conditio altercations and act reports or allegatior abuse will be taken investigated. Inves identify what happe immediately after in	Prevention Program: revised taff to do the following: cidents, accidents, injuries, n, resident to resident that or suspected abuse as of actual or suspected seriously and thoroughly tigation is a process used to ned. Investigation begins cidents, mistreatment, ppropriation of property				

Minnesota Department of Health

PRINTED: 09/14/2015 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00407	B. WING		08/13/2015	
	PROVIDER OR SUPPLIER	965 MCM	DRESS, CITY, S ILLAN STRE IGTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21995	occurs or a report of "REPORTING AND are mandated repore report incidents, ac injuries of unknown change of conditional tercations and ac Charge Nurse on d Social Service Dire Accidents involving and actual or suspe Mistreatment, exploof property will be reported by the Administrator of Hear Another policy titled Immediate Reporting Mistreatment, Neglia Administrator dated notify the administrator or suspected abuse Review of the Resident of S/24/15. The incide an injury of unknow of incident was man "Describe EXACTL bruise found during left inner thigh 1 me cm there [sic] other section noted a bood drawn on left inner page of Resident In which indicated R3 which was marked as being 'confused' form went on to not on 5/26/15, at 7:00	of same is received." RESPONSE: All employees refers. Staff is expected to cidents, injuries (including origin), medication errors, a, resident to resident tual or suspected abuse to the uty or the Director of Nursing, ctor and the Administrator. injury, unexplained injuries exted abuse, neglect, bitation and misappropriation eported to the Minnesota lth (online) within 24 hours." I Delegation of Authority for any of Actual or Alleged ect or Abuse in Absence of 16/13/15, instructed staff to ator immediately when actual	21995			

Minnesota Department of Health

STATE FORM 6899 WNSR11 If continuation sheet 33 of 35

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED					
	00407	B. WING		08/1	3/2015					
PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•						
CROSSROADS CARE CENTER 965 MCMILLAN STREET WORTHINGTON, MN 56187										
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	CTION SHOULD BE COMPLETI O THE APPROPRIATE DATE						
days after the incide administrator notific time. The section of was void of an mark. The care plan dated being to report abus R33 Minimum Data R33's cognition was required extensive abed mobility, transfet toileting. On 8/12/15, at 2:19 stated, "We have to immediately. We have to immediately. We have abuse or neglect with abuse or neglect with abuse we let state a When asked where administrator was now do not write it or have kept a record incident had not be on 8/12/15, at 3:27 administrator said, incidents that are al 10:00 p.m. or when instances of true abuse and write notifit the back of the form did the administrator. SUGGESTED MET	ent happened). The cation was void of date and f notifying common entry point kings. d 9/19/11, noted R33 was not se due to cognitive loss. Set dated 5/18/15, indicated a moderately impaired. R33 cassistance from the staff with ers, dressings, eating and p.m. social worker (SW)-A to let the administrator know ave to report allegations of thin 24 hours. If we know it is agency know immediately." It was documented that the notified, SW-A stated, "I guess in the form. I don't think we of it." SW-A revealed the en called into the SA. p.m. during an interview the "I truly believe we have no buse. I am notified before I get up in am except in ouse." We tell the staff to be location (of administrator) on in. I don't keep a log." The dinot include the notification of the common o	21995								
immediately reporte	ed to the state agency and that									
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa days after the incide administrator notific time. The section of was void of an mark The care plan dated being to report abus R33 Minimum Data R33's cognition was required extensive a bed mobility, transfe toileting. On 8/12/15, at 2:19 stated, "We have to immediately. We ha abuse or neglect wi abuse we let state a When asked where administrator was n we do not write it or have kept a record incident had not bed On 8/12/15, at 3:27 administrator said, incidents that are al 10:00 p.m. or when instances of true ab sure and write notifi the back of the form die the administrator. SUGGESTED MET The facility could as potential abuse are immediately reporter	PROVIDER OR SUPPLIER STREET ADI ROADS CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 33 days after the incident happened). The administrator notification was void of date and time. The section of notifying common entry point was void of an markings. The care plan dated 9/19/11, noted R33 was not being to report abuse due to cognitive loss. R33 Minimum Data Set dated 5/18/15, indicated R33's cognition was moderately impaired. R33 required extensive assistance from the staff with bed mobility, transfers, dressings, eating and toileting. On 8/12/15, at 2:19 p.m. social worker (SW)-A stated, "We have to let the administrator know immediately. We have to report allegations of abuse or neglect within 24 hours. If we know it is abuse we let state agency know immediately." When asked where it was documented that the administrator was notified, SW-A stated, "I guess we do not write it on the form. I don't think we have kept a record of it." SW-A revealed the incident had not been called into the SA. On 8/12/15, at 3:27 p.m. during an interview the administrator said, "I truly believe we have no incidents that are abuse. I am notified before 10:00 p.m. or when I get up in am except in instances of true abuse." We tell the staff to be sure and write notification (of administrator) on the back of the form. I don't keep a log." The back of the form did not include the notification of	OPPONIDER OR SUPPLIER ODADS CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 33 days after the incident happened). The administrator notification was void of date and time. The section of notifying common entry point was void of an markings. The care plan dated 9/19/11, noted R33 was not being to report abuse due to cognitive loss. R33 Minimum Data Set dated 5/18/15, indicated R33's cognition was moderately impaired. R33 required extensive assistance from the staff with bed mobility, transfers, dressings, eating and toileting. On 8/12/15, at 2:19 p.m. social worker (SW)-A stated, "We have to let the administrator know immediately. We have to report allegations of abuse or neglect within 24 hours. If we know it is abuse we let state agency know immediately." When asked where it was documented that the administrator was notified, SW-A stated, "I guess we do not write it on the form. I don't think we have kept a record of it." SW-A revealed the incident had not been called into the SA. On 8/12/15, at 3:27 p.m. during an interview the administrator said, "I truly believe we have no incidents that are abuse. I am notified before 10:00 p.m. or when I get up in am except in instances of true abuse." We tell the staff to be sure and write notification (of administrator) on the back of the form. I don't keep a log." The back of the form old not include the notification of the administrator. SUGGESTED METHOD OF CORRECTION: The facility could assure that all allegations of potential abuse are thoroughly investigated and immediately reported to the state agency and that	OF CORRECTION DIENTIFICATION NUMBER: 00407 **STREET ADDRESS, CITY, STATE, ZIP CODE 965 MCMILLAN STREET WORTHINGTON, MN 56187 **SUMMARRY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 33 days after the incident happened). The administrator rotification was void of date and time. The section of notifying common entry point was void of an markings. The care plan dated 9/19/11, noted R33 was not being to report abuse due to cognitive loss. R33 Minimum Data Set dated 5/18/15, indicated R33's cognition was moderately impaired. R33 required extensive assistance from the staff with bed mobility, transfers, dressings, eating and toileting. On 8/12/15, at 2:19 p.m. social worker (SW)-A stated, "We have to let the administrator know immediately." We have to report allegations of abuse or neglect within 24 hours. If we know it is abuse we let state agency know immediately," When asked where it was documented that the administrator was notified, SW-A stated, "I guess we do not write in on the form. I don't think we have kept a record of it." SW-A revealed the incident had not been called into the SA. On 8/12/15, at 3:27 p.m. during an interview the administrator said, "It truly believe we have no incidents that are abuse. I am notified before 10:00 p.m. or when I get up in am except in instances of true abuse." We tell the staff to be sure and write notification (of administrator) on the back of the form. I don't keep a log." The back of the form. I don't keep a log." The back of the form. I don't keep a log." The back of the form. I don't keep a log." The back of the form it don't keep a log." The back of the form it don't keep a log." The back of the form the the state agency and that incidents and inmediately reported to the state agency and that	OPPOVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 965 MCMILLAN STREET WORTHINGTON, MN 56187 SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MIST BE PRECEDED BY PULL REGULATORY OR ILSC DENTIFYNION INFORMATION). Continued From page 33 days after the incident happened). The administrator notification was void of date and time. The section of notifying common entry point was void of an markings. The care plan dated 9/19/11, noted R33 was not being to report abuse due to cognitive loss. R33 Minimum Data Set dated 5/18/15, indicated R33's cognition was moderately impaired. R33 required extensive assistance from the staff with bed mobility, transfers, dressings, eating and tolleting. On 8/12/15, at 2:19 p.m. social worker (SW)—A stated, "We have to report allegations of abuse or neglect within 24 hours. If we know it is abuse we let state agency know immediately." When asked where it was documented that the administrator was notified, SW—A stated, "I guess we do not write it on the form. I don't think we have kept a record of it." SW—A revealed the incident had not been called into the SA. On 8/12/15, at 3:27 p.m. during an interview the administrator said, "I truly believe we have no incidents that are abuse. I am notified before 10:00 p.m. or when I get up in am except in instances of true abuse." We tell the staff to be sure and write notification (of administrator) on the back of the form id not include the notification of the administrator. SUGGESTED METHOD OF CORRECTION: The facility could assure that all allegations of potential abuse are thoroughly investigated and immediately reported to the state agency and that					

Minnesota Department of Health

STATE FORM 6899 WNSR11 If continuation sheet 34 of 35

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY					
		00407	B. WING		08/1	13/2015					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE OCE MONULLAN CIPEET											
CROSSROADS CARE CENTER 965 MCMILLAN STREET WORTHINGTON, MN 56187											
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE					
21995	1 0		21995								
	while an investigation is pending. The Administrator, director of nursing and/or designee could assure policies are reviewed, up to date, implemented and and that staff training has been completed.										
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One									

Minnesota Department of Health