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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WNSR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00407

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245395**
2.STATE VENDOR OR MEDICAID NO.
(L2) **146319500**

3. NAME AND ADDRESS OF FACILITY
(L3) **CROSSROADS CARE CENTER**
(L4) **965 MCMILLAN STREET**
(L5) **WORTHINGTON, MN** (L6) **56187**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/26/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 10/01/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/01/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 Fiske-Downing

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245395	A. Building B. Wing	9/26/2015

Name of Facility	Street Address, City, State, Zip Code
CROSSROADS 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 **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **09/22/2015**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **09/22/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **09/22/2015**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **09/22/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **08/17/2015**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **09/22/2015**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **09/09/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **09/22/2015**	ID Prefix **F0492** Reg. # **483.75(b)** LSC	Correction Completed **09/14/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/kfd	10/01/2015	10160	09/26/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/13/2015

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245395	A. Building B. Wing **01 - MAIN BUILDING 01**	9/14/2015

Name of Facility	Street Address, City, State, Zip Code
CROSSROADS 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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0029	**08/11/2015**	ID Prefix Reg. # **NFPA 101** LSC K0076	**08/11/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	GS/kfd	10/01/2015	35482	09/14/2015
Reviewed By CMS RO				

Followup to Survey Completed on: 8/11/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: WNSR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00407

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245395**

2.STATE VENDOR OR MEDICAID NO.
(L2) **146319500**

3. NAME AND ADDRESS OF FACILITY
(L3) **CROSSROADS CARE CENTER**
(L4) **965 MCMILLAN STREET**
(L5) **WORTHINGTON, MN** (L6) **56187**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/13/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Jares Magdalene, HFE NEII — 09/14/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 09/30/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

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

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/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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING _____ B. WING _____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSROADS CARE CENTER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow up on resident concerns regarding assistance with activities of living (ADLs) for 1 of 1 resident (R31) who voiced a concern of being denied assistance. Findings include: On 8/11/15, at 9:04 a.m. R31 stated there was one aide on nights he was always kind of rude. During continuous observations on 8/12/15, from 8:55 a.m. to 9:45 a.m. R31 was observed to request assistance from nursing staff to walk to	F 166	It is the facility's policy to investigate and resolve resident grievances. For R31: The facility respectfully disagrees with the surveyor's description of the conversation 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 handwritten report of the investigation included the following information: R31 reported to the	9/22/15

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

Electronically Signed | 09/07/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING _____ B. WING _____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSROADS CARE CENTER	965 MCMILLAN STREET WORTHINGTON, MN 56187

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F 166	Continued From page 1 the bathroom and waited until staff were available to walk with her in accordance with her care plan. R31's care plan dated 4/2/15, instructed staff to assist R31 with ambulation using a front wheeled walker. R31 was to be assisted with toileting, and transfers on and off the toilet. R31's Individual abuse prevention plan indicated "... could accurately report abuse." The quarterly Minimum Data Set on 7/30/15, indicated R31's was alert and oriented and no history of falling in the last six months. On 8/12/15, at 8:30 a.m. registered Nurse (RN)-D was interviewed and stated there was only one nurse on at night. "Luckily I have seasoned staff. I expect them to follow the care plans. I have had no reports of difficulty following the care plan." - At 2:19 p.m. social worker (SW)-A was asked if R31 had ever told her that a staff member told R31 to walk to the bathroom by self. SW-A said, "Yes, I shared that with nursing. [R31] just told me last Thursday, that a nursing assistant [NA] had refused to provide assistance to the bathroom. [R31] tends to exaggerate things known to complain against the particular man who was working that night. He [male NA] has never had any complaints. R31 is a miserable lady." SW-A further commented, "If you have a staff person who tells a resident to do something different from the care plan 'that would neglect.'" On 8/12/15, at 3:42 p.m. SW-A provided a copy of investigation of R31's concerns. The untitled handwritten document dated 8/6/15, noted the following: The date of the alleged event was not identified, the alleged perpetrator, identified by R31 was not identified by name or length of	F 166	SW on 8-6-15 at 9:10 AM that "A tall black man doesn't help me when I need help." SW asked resident if her call light was on and exactly what had happened. R31 stated, "I had my light on and a tall black man came in and said, "[R31] what do you need?" R31 stated she told him, "I need the bathroom." R31 stated to SW that the CNA responded, "Well then go and then he stood in the hallway not helping me pull my pants down or up." SW asked R31 if pulling her pants down was difficult for her. R31 replied, "No, I did it but he is supposed to help me." SW interviewed CNA in question on 8-7-15. SW described allegation made of him by R31. CNA stated to SW, "No, she is usually in the bathroom by the time I get there to answer her call light." SW: "What do you do then?" CNA: "I wait by the bathroom door until she is done and make sure she gets back to bed safely." SW: "Do you assist her in pulling up her pants?" CNA: "No, she has always done that." SW: "Would you assist her if she needed help?" CNA: "Yes Ma'am, that's why I'm here." SW did interview a few more residents who require assistance with toileting regarding the care/assistance they are receiving. No concerns were voiced about this CNA or any CNAs. The facility also respectfully disagrees with the surveyor's statement that the SW stated "R31 is a miserable lady." SW has no recollection of making that comment.	

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F 166	Continued From page 2 service, the possible contributing factors were not identified. The document indicated that the facility had "interviewed a few more Residents regarding cares/assistance by overnight aids-no concerns voiced." No conclusion was documented. It could not be determined from reading the document what the resolution of investigation had identified, and/or whether the resident had been informed of the resolution/decision.	F 166	SW does recall telling surveyor that R31 "is an unhappy lady". (SW has heard R31's daughter refer to her mother as "a miserable lady". SW speculates that surveyors may have talked to R31's daughter during the survey and confused SW's statement about R31 being an unhappy lady with daughter's description of her mother being a miserable lady.) The SW did talk with surveyors about R31's history of exaggerating details and being prejudiced. R31's history of exaggeration and prejudice is addressed in her care plan and SW's quarterly documentation. Since the surveyor reported R31's concern to the SW, the SW has been checking with R31 daily, when SW is at work, to provide time for R31 to express any concerns she has regarding her cares and assistance from staff and offering education to R31 frequently regarding the importance of reporting her concerns to the Charge nurse. Staff education has 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/Concerns form and routed to related Department Heads (DH). If the concern meets the definition of actual or potential abuse/neglect, the Administrator shall be notified immediately and will delegate staff per the facility's Abuse Prevention Plan (policy/procedure) to file an initial online report with OHFC.	

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F 166	Continued From page 3	F 166	Investigation will then be completed by the applicable DH. Results of DH investigation will be reviewed with the DH and Director of Nursing, Social Services Director and Administrator, a plan of correction/resolution will be determined and findings/plan of correction/resolution will be reviewed with the concerned party within seven (7) days by the Director of Nursing, Social Services Director or DH. Staff education will be completed if findings result in changes in policy/procedure. If an initial report was filed with OHFC, the DON or SW will file a final investigation report within 5 days of the initial report. Weekly follow-ups will be completed with R31 to ensure R31's satisfaction. The results of this follow up will be reviewed at quarterly QA meeting to determine if plans of action/resolution have been successful or if modifications are indicated. For All Other Residents: 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/Concerns form and routed to related Department Heads (DH). If the concern meets the definition of actual or potential abuse/neglect, the Administrator shall be notified immediately and will delegate staff per the facility's Abuse Prevention Plan (policy/procedure) to file an initial online report with OHFC.	

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F 166	Continued From page 4	F 166	Investigation will then be completed by the applicable DH. Results of DH investigation will be reviewed with the DH and Director of Nursing, Social Services Director and Administrator, a plan of correction/resolution will be determined and findings/plan of correction/resolution will be reviewed with the concerned party within seven (7) days by the Director of Nursing, Social Services Director or DH. Staff education will be completed if findings result in changes in policy/procedure. If an initial report was filed with OHFC, the DON or SW will file a final investigation report within 5 days of the initial report. SW will maintain a log of grievances and outcomes which will be reviewed by the QA Committee quarterly to determine if resolution of grievances is effective/or modifications indicated.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	F 225		9/22/15

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F 225	Continued From page 5 The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews and document review the facility failed to immediately report to administrator and State agency (SA) and thoroughly investigate an allegation of an injury of unknown origin 1 of 4 residents (R33) reviewed for abuse prohibition. Findings include: Review of the Resident Incident Reports from 5/1/15, going forward noted the following: R33 had a Resident Incident Report dated 5/24/15. The incident alleged R33 had sustained	F 225	The facility's policy is to ensure that all incidents, accidents and alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the Administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency) and thoroughly investigates the same. For R33:	

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F 225	Continued From page 6 an injury of unknown origin in the groin. The time of incident was marked as a.m. The section "Describe EXACTLY what happened " reported " bruise found during AM cares-2 bruises noted on left inner thigh 1 measures 1 cm. [centimeter] x 2 cm there [sic] other measures 2 cm x 2 cm." The section noted a body diagram which had a circle drawn on left inner thigh, near the groin. The back page of Resident Incident Report had a box which indicated R33 had an unexplained injury which was marked "Yes." The form depicted R33 as being ' confused ' and ' totally disoriented. ' The form went on to note that social services notified on 5/26/15, at 7:00 a.m. The director of nursing (DON) was notified on 5/26/15, at 8:30 a.m. (two 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.	F 225	The facility respectfully disagrees that this incident should have been reported to the State agency and that it did not thoroughly investigate this incident. The surveyor's findings as stated on the 2567 (Statement of Deficiencies) do not state that there was no evidence to indicate that the incident was investigated by the facility staff nor do the findings state that the facility, after investigation, came to the conclusion that the cause for the bruise could not be determined. The DON did investigate this incident as evidenced by the incident report. The DON states in the incident report "Unable to identify specific contact surface for bruising (L) inner thigh. Resident says "No" when asked if hurt by someone. Limited cognition, no verbal body language indicating someone may have mistreated her. Possibly benefit from PT eval-exercise plan within limits of resident's chronic health conditions. Quad muscle tight, holds legs tight. Limited abduction." The DON also noted on the incident report that the resident is "on Coumadin-bleed risk". The incident report for R33 and investigation information was reviewed again by the DON subsequent to the surveyor's findings. The DON came to the conclusion that the bruising was most likely due to the placement of the resident's incontinence product insert/snap pants bunching up against the thigh causing a bruise related to being "on Coumadin-bleed risk". The DON also interviewed the RCC and Charge Nurse	

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F 225	Continued From page 7 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 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 the administrator. Abuse Prevention Program: revised 4/16/08, instructed staff to: "Investigation: All incidents, accidents, injuries, changes of condition, resident to resident altercations and actual or suspected abuse reports or allegations of actual or suspected abuse will be taken seriously and thoroughly investigated. Investigation is a process used to identify what happened. Investigation begins immediately after incidents, mistreatment, exploitation or misappropriation of property occurs or a report of same is received." "REPORTING AND RESPONSE: All employees are mandated reporters. Staff is expected to report incidents, accidents, injuries (including injuries of unknown origin), medication errors, change of condition, resident to resident altercations and actual or suspected abuse to the Charge Nurse on duty or the Director of Nursing, Social Service Director and the Administrator. Accidents involving injury, unexplained injuries and actual or suspected abuse, neglect, Mistreatment, exploitation and misappropriation of property will be reported to the Minnesota Department of Health (online) within 24 hours. Another policy titled Delegation of Authority for Immediate Reporting of Actual or Alleged Mistreatment, Neglect or Abuse in Absence of	F 225	separately. After considering the location of the bruise and possible causes, both nurses came to the same conclusion independently of the DON. Retroactively, it is concluded that the bruising was caused by the bunching up of the incontinence product insert/snap pants and the predisposition for bleeding/bruising due to Coumadin use and limited abduction. Reeducation is being provided to CNAs in small huddles (individually and small groups) on correct placement of incontinence product to avoid accidental injury and will be completed by 09/22/15. DON will randomly audit one resident on each unit for six weeks for proper application of incontinence product/snap pants by CNAs. Results of audits will be reviewed at quarterly QA meeting to determine if plan of action is effective/or modifications indicated. For All Residents: The facility's Abuse Prevention Program, including but not limited to abuse prevention policies, reporting procedures and investigation procedures has been reviewed and revised. The incident report has been revised to include specific instructions to call the Administrator immediately if there is actual or suspected mistreatment, abuse, neglect or misappropriation of resident's funds by an employee, family member or visitor; a resident sustains an injury requiring a physician visit/transport to emergency	

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F 225	Continued From page 8 Administrator dated 6/13/15, instructed staff to notify the administrator immediately when actual or suspected abuse occurs.	F 225	room; an injury of unknown cause or a resident-to-resident altercation. ("Immediately" means 24/7/365 as soon as possible/practical after the resident's needs have been met but no later than the end of the shift.) Calls to the Administrator will be logged by the nurse making the call and by the Administrator taking the call and also noted on the incident report, including the Administrator's response and decision as to whether to initiate report to OHFC. If the incident is determined by the Administrator to be reportable to OHFC, the DON, DON's designee or Social Service Director will file the report as soon as possible/practical but no later than the end of the shift. In their absence, the Charge Nurse will file the initial OHFC report online as soon as possible/practical but no later than end of the Charge Nurse's shift. The Director of Nursing will direct the full investigation and will file the final investigative report with OHFC within five days of the initial report. All incidents are thoroughly investigated by facility staff. Results of investigation are reviewed by the Director of Nursing, Social Services Director and Administrator. Incident reports and results of investigation are also reviewed by the Risk Management Committee weekly and a root cause analysis is completed to determine if further action/follow-up is needed. The Director of Nursing will maintain a log of all incident reports going forward and provide a summary report of same to the QA	

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F 225	Continued From page 9	F 225	committee each quarter for review and further recommendations. Nursing staff has been re-educated as to the requirement to call the Administrator immediately. The revised Abuse Prevention Plan will be reviewed with licensed nurses at an in-service by September 22, 2015 that will be presented by the Director of Nursing and the Administrator.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interviews and document review the facility failed to immediately report to administrator and State agency (SA) and thoroughly investigate an allegation of an injury of unknown origin 1 of 4 residents (R33) reviewed for abuse prohibition. Findings include: The facility's Abuse Prevention Program: revised 4/16/08, informed staff to do the following: "Investigation: All incidents, accidents, injuries, changes of condition, resident to resident altercations and actual or suspected abuse reports or allegations of actual or suspected	F 226	The facility's policy is to ensure that all incidents, accidents and alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the Administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency) and thoroughly investigates the same. For R33: The facility respectfully disagrees that this	9/22/15

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F 226	Continued From page 10 abuse will be taken seriously and thoroughly investigated. Investigation is a process used to identify what happened. Investigation begins immediately after incidents, mistreatment, exploitation or misappropriation of property occurs or a report of same is received." "REPORTING AND RESPONSE: All employees are mandated reporters. Staff is expected to report incidents, accidents, injuries (including injuries of unknown origin), medication errors, change of condition, resident to resident altercations and actual or suspected abuse to the Charge Nurse on duty or the Director of Nursing, Social Service Director and the Administrator. Accidents involving injury, unexplained injuries and actual or suspected abuse, neglect, Mistreatment, exploitation and misappropriation of property will be reported to the Minnesota Department of Health (online) within 24 hours." Another policy titled Delegation of Authority for Immediate Reporting of Actual or Alleged Mistreatment, Neglect or Abuse in Absence of Administrator dated 6/13/15, instructed staff to notify the administrator immediately when actual or suspected abuse occurs." Review of the Resident Incident Reports from 5/1/15, going forward noted the following: R33 had a Resident Incident Report dated 5/24/15. The incident alleged R33 had sustained an injury of unknown origin in the groin. The time of incident was marked as a.m. The section "Describe EXACTLY what happened" reported bruise found during AM cares-2 bruises noted on left inner thigh 1 measures 1 cm. [centimeter] x 2 cm there [sic] other measures 2 cm x 2 cm." The section noted a body diagram which had a circle drawn on left inner thigh, near the groin. The back page of Resident Incident Report had a box	F 226	incident should have been reported to the State agency and that it did not thoroughly investigate this incident. The surveyor's findings as stated on the 2567 (Statement of Deficiencies) do not state that there was no evidence to indicate that the incident was investigated by the facility staff nor do the findings state that the facility, after investigation, came to the conclusion that the cause for the bruise could not be determined. The DON did investigate this incident as evidenced by the incident report. The DON states in the incident report "Unable to identify specific contact surface for bruising (L) inner thigh. Resident says "No" when asked if hurt by someone. Limited cognition, no verbal body language indicating someone may have mistreated her. Possibly benefit from PT eval-exercise plan within limits of resident's chronic health conditions. Quad muscle tight, holds legs tight. Limited abduction." The DON also noted on the incident report that the resident is "on Coumadin-bleed risk". The incident report for R33 and investigation information was reviewed again by the DON subsequent to the surveyor's findings. The DON came to the conclusion that the bruising was most likely due to the placement of the resident's incontinence product insert/snap pants bunching up against the thigh causing a bruise related to being "on Coumadin-bleed risk". The DON also interviewed the RCC and Charge Nurse separately. After considering the location of the bruise and possible causes, both	

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F 226	Continued From page 11 which indicated R33 had an unexplained injury which was marked "Yes." The form depicted R33 as being 'confused' and 'totally disoriented.' The form went on to note that social services notified on 5/26/15, at 7:00 a.m. The director of nursing (DON) was notified on 5/26/15, at 8:30 a.m. (two 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 the administrator.	F 226	nurses came to the same conclusion independently of the DON. Retroactively, it is concluded that the bruising was caused by the bunching up of the incontinence product insert/snap pants and the predisposition for bleeding/bruising due to Coumadin use and limited abduction. Reeducation is being provided to CNAs in small huddles (individually and small groups) on correct placement of incontinence product to avoid accidental injury and will be completed by 09/22/15. DON will randomly audit one resident on each unit for six weeks for proper application of incontinence product/snap pants by CNAs. Results of audits will be reviewed at quarterly QA meeting to determine if plan of action is effective/or modifications indicated. For All Residents: The facility's Abuse Prevention Program, including but not limited to abuse prevention policies, reporting procedures and investigation procedures has been reviewed and revised. The incident report has been revised to include specific instructions to call the Administrator immediately if there is actual or suspected mistreatment, abuse, neglect or misappropriation of resident's funds by an employee, family member or visitor; a resident sustains an injury requiring a physician visit/transport to emergency room; an injury of unknown cause or a resident-to-resident altercation.	

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	245395	A. BUILDING _____ B. WING _____	08/13/2015

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F 226	Continued From page 12	F 226	("Immediately" means 24/7/365 as soon as possible/practical after the resident's needs have been met but no later than the end of the shift.) Calls to the Administrator will be logged by the nurse making the call and by the Administrator taking the call and also noted on the incident report, including the Administrator's response and decision as to whether to initiate report to OHFC. If the incident is determined by the Administrator to be reportable to OHFC, the DON, DON's designee or Social Service Director will file the report as soon as possible/practical but no later than the end of the shift. In their absence, the Charge Nurse will file the initial OHFC report online as soon as possible/practical but no later than end of the Charge Nurse's shift. The Director of Nursing will direct the full investigation and will file the final investigative report with OHFC within five days of the initial report. All incidents are thoroughly investigated by facility staff. Results of investigation are reviewed by the Director of Nursing, Social Services Director and Administrator. Incident reports and results of investigation are also reviewed by the Risk Management Committee weekly and a root cause analysis is completed to determine if further action/follow-up is needed. The Director of Nursing will maintain a log of all incident reports going forward and provide a summary report of same to the QA committee each quarter for review and further recommendations.	

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F 226	Continued From page 13	F 226	Nursing staff has been re-educated as to the requirement to call the Administrator immediately. The revised Abuse Prevention Plan will be reviewed with licensed nurses at an in-service by September 22, 2015 that will be presented by the Director of Nursing and the Administrator.	
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		9/22/15

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F 329	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 3 of 6 residents (R49, R2, R20) had adequate monitoring for psychotropic 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 table. -At 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 recliner. -At 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. R49's diagnoses included dementia with behavioral disturbance, insomnia and dysthymic disorder obtained from admission face sheet dated 6/2/15. In addition the admission face sheet revealed an admission date of 6/1/15. Admission MDS dated 6/8/15, indicated R49 received both antipsychotic and antidepressant medications daily and was noted R49 had behaviors. R49's fall Care Area Assessment (CAA) dated 6/14/15, indicated R49 was at risk for falls, wandered, had impaired balance/gait and used an antidepressant. Psychotropic drug medication CAA dated 6/14/15, indicated R49 used antidepressant and antipsychotic medications. The CAA indicated R49 was at risk for	F 329	It is the facility's policy is that each resident's drug regimen will be free from unnecessary drugs. Survey findings state that R49, R2, and R20 records did not have documentation of monitoring for orthostatic hypotension. The Plan of Correction for residents R49, R2 and R20 is the same as for all residents. The facility's policy for use of psychoactive medications has been reviewed and revised to include baseline orthostatic B/P monitoring for all residents on psychotropic medications during the initial MDS admission assessment reference window. Orthostatic blood pressures will be monitored thereafter on monthly basis by Charge Nurses and reported to Resident Care Coordinators (RCC). RCC will audit monthly to ensure completion. Abnormal findings will be reported to resident's physician and Consulting Pharmacist (CP). Orthostatic B/P monitoring will also be completed by Charge Nurses post fall or if significant change in resident condition indicates need for orthostatic B/P monitoring. Findings will be reported to RCC. Resident's physician and CP will be updated of abnormal findings. An in-service for nursing staff who administer medications (licensed nurses and TMAs) will be held by 09/22/15.	

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F 329	Continued From page 15 psychotropic drug side effects. CAA directed staff to monitor for response and any changes in resident physical and mental status however did not indicate address when and how often to monitor for orthostatic BP's. R49's psychotropic drug use care plan dated 6/21/15, indicated R49 was at risk for adverse effects related to use of medications. The care plan directed to monitor R49 for potential side effects, orthostatic's per protocol and monitor movement disorder DISCUS per policy. R49's Physician's Orders Sheet dated 7/22/15, revealed the following orders: -Depakote (mood stabilizer) sprinkles 250 milligrams (mg) by mouth (PO) three times daily (TID) for dementia with behavioral disturbance. -Remeron (antidepressant) 30 mg PO give one daily for dysthymic disorder. -Risperdal 0.25 mg PO morning only give daily for dementia with behavioral disturbance. A review of the medical record from 6/1/15, revealed the medical record lacked documentation of orthostatic blood pressure (BPs). In addition indicated R49 had been lowered to the floor on 7/13/15, no injuries sustained however orthostatic blood pressures had not been done either at the time of the incident. On 8/12/15, at 2:25 p.m. RN-A stated orthostatic BP's were usually done on admission and if the doctor had ordered them. RN-A verified orthostatic B/P's had not been done on admission 6/1/15, after she went through the admit evaluation. RN-A further stated R49 had refused some vital signs at the time of admission but had	F 329	Documentation records will be audited monthly by the DON. Results of audits will be reviewed at quarterly QA meeting to determine if plan of action is effective/or modifications indicated.	

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F 329	Continued From page 16 not been re-attempted. On 8/13/15, at 12:13 p.m. when asked what the facility protocol was for monitoring/checking orthostatic blood pressures DON stated for all residents who were on psychotropic medications and were at risk for falls they were supposed to be done monthly but would be deferred if a resident was not ambulating, did not transfer self or did not reposition themselves. DON further stated when a resident was initially admitted to the facility orthostatic BP's were supposed to be done but at times it would be difficult to obtain them. -At 1:06 p.m. DON stated although it was difficult to obtain orthostatic BP's initially when residents were admitted due to adjustment and behaviors she acknowledged the nurses should have attempted later to obtain the BP's. DON further stated the resident care coordinators were responsible for making sure the DISCUS assessment were accurately completed and the CP should have caught it but thought the assessment had been done prior to the current CP as the facility had switched pharmacists. R2's quarterly MDS dated 5/11/15, indicated R2 was admitted to the facility on 2/2/09. Admission 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.	F 329		

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F 329	Continued From page 17 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. R2's physician orders dated 8/11/15, included Zyprexa (antipsychotic) 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. 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. R20's quarterly MDS dated 7/17/15, indicated R20 was admitted to the facility on 6/8/10. Admission diagnoses included hypertension, depression, and schizophrenia. R20's quarterly Minimum Data Set (MDS) dated 8/13/15, indicated R20 received both antipsychotic and antidepressant medications daily and was noted R20 refused cares.	F 329		

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F 329	Continued From page 18	F 329		

R20's CAA dated 8/13/15, indicated R20 did not exhibit behaviors. In addition care Plan dated 8/13/15, indicated R20 had history of depression as evidenced by display of little interest in participating with cares, therapy, activities, blunted affect, disconnect. R20 was resistive to cares, would not allow staff to provide cares/therapy at times.

R20's physician orders dated 8/12/15, indicated R20 received Risperdal 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.

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.

On 8/13/15, at 10:57 a.m. licensed practical nurse (LPN)-B stated they do orthostatic blood pressures on admission. LPN-A further stated they may do them if physician orders it or they have an indication for it.

On 8/13/15, at 11:11 a.m. DON stated they do orthostatic blood pressures with initial admission

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F 329	Continued From page 19 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 assist in assessing appropriateness, effectiveness, and possible adverse consequences of the medications covered by the policy."	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. 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. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community	F 356		8/17/15

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F 356	Continued From page 20 standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Report 0f Nursing Staff Directly Responsible For Resident Care (RoNS) was updated daily to reflect actual hours worked. This practice had the potential to affect all 39 residents who resided in the facility, family and visitors who wished to view this information. Findings include: During the initial tour on 8/10/15, at 3:30 p.m. the RoNS was observed posted on the wall in the facility's main lobby. The posting included the facility name, current resident census, hours of 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	F 356	It is the facility's policy that the Report of Nursing Staff Directly Responsible for Resident Care (RoNS) is posted in the lobby on a daily basis at beginning of each shift. The facility's policy has been reviewed and revised to ensure that this requirement is met. The Staffing Scheduler is responsible for posting staffing information during weekdays and the East Charge Nurse is designated to post staffing information on weekends and in absence of Staffing Scheduler. The East Charge Nurse will be advised if Staffing Scheduler will be absent. These changes were reviewed on 08/13/15 with Staffing Scheduler and Charge Nurses and on 8/17/15 with RCCs who are also nursing unit supervisors. The DON will audit randomly, at least twice a week for six weeks and weekly thereafter, to ensure that the RoNS is posted with correct date, correct census and staffing information and report results of audits at the next Quarterly QA meeting at which time the results of the audits will be reviewed to determine if plan of action	

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F 356	Continued From page 21 dated 8/11/15, census 40. On 8/11/15, at 10:57 a.m. the posted RoNS was dated 8/11/15, census 40. On 8/12/15, at 7:26 a.m. the posted RoNS was dated 8/11/15, census 40. On 8/12/15, at 10:02 a.m. the posted RoNS was dated 8/11/15, census 40. On all days of the survey the current census of the facility remained 39 and the RoNS was not updated to reflect the current census of the facility. On 8/13/15, at 11:56 a.m. the staffing coordinator stated she was responsible for updating the RoNS when she received them. She added she did not know who was responsible for updating the actual hours on the RoNS or posting the current one daily on the week-ends. - At 1:47 p.m. the staffing coordinator stated that what was posted for staff posting when she left for the day were the hours the people who were scheduled were to work when she left. If call-ins were received after she left it was not changed until the next day, when she came. - At 3:19 p.m. director of nurses stated the staffing hours are to be posted every morning and updated as needed. The facility provided a policy Posting Direct Care Staffing Numbers dated 9/5/12, stated "1. Each morning the number of Licensed Nurse and the number of unlicensed nursing personal directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format."	F 356	is effective/or modifications indicated.	
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425		9/22/15

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F 425	Continued From page 22 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure expired medications were not available for use in 2 of 2 medication carts. In addition, the facility failed to ensure medications with a short shelf life were dated when opened. Findings include: South Unit On 8/13/15, at 10:42 a.m. during a tour was conducted of medication storage areas with licensed practical nurse (LPN)-B, and registered nurse (RN)-B, who provided access to the cart during the tour. During the tour the following	F 425	It is the facility's policy to provide pharmacy services including procedures that assure the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals to meet the needs of the resident. In addition it is the facility's policy to employ or obtain the services of a licensed pharmacist that provides consultation on all aspects of the provision of pharmacy services in the facility, establishes a system of records of receipt and disposition of all controlled drugs/expired drugs in sufficient detail to support an accurate reconciliation and determines that drug records are in order	

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F 425	Continued From page 23 concerns were identified: -Low dose safety coated Aspirin (a mild analgesic) 81 milligrams (mg) 500 bottle with an expiration date of 7/15. -Enteric coated Aspirin 81 mg analgesic (a house stock bottle of 1000 tablets) with an expiration date of 3/15. -Benadryl (anti-histamine) 25 mg 22 tablets, with an expiration date of 1/15. -Serevent Diskus (breathing medication) 50 micrograms (mcg) for R2, was not dated when opened. -Multi-vitamin with minerals 100 tablets with expiration date 10/14. -Advair Diskus (breathing medication) aerosol 250/50 mcg for R15, was not dated when opened. At the time of the tour, LPN-B stated medications should be dated when opened, and verified expired medications were not supposed to be stored in the medication cart where they would be available for use. LPN-B stated the night nurse was responsible to make sure expired medications were not available for use. On 8/13/15, at 10:51 a.m. the director of nursing (DON) stated inhalers were supposed to be dated when opened, and verified the nurses were supposed to look at the labels when preparing medications, and should remove expired medications from the medication carts. 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	F 425	and that an accounting of all controlled medications is maintained and periodically reconciled. The facility's policy and procedure for identifying and removing expired medications and treatment supplies has been reviewed and revised. Expired medications and treatment supplies identified during survey have been disposed of and replaced. Opened/undated medications have also been disposed of and replaced. All nursing staff (licensed nurses and TMAs) is responsible for ensuring that medications are not expired and medications with a short shelf life are dated when opened, before administering medication. Nursing staff has been reminded to check expiration dates on medications prior to administration and to date medications with a short life when opened. An in-service will be held by 9/22/15 to review facility policies and procedures with licensed nursing staff and trained medication assistants. The DON or delegated RCC and Charge Nurse from each unit will audit medication carts and medication storage areas monthly, remove/dispose of any expired medications/treatment supplies and/or undated medications with a short life, replace if needed and document findings. Results of audits will be reviewed at the next Quarterly QA meeting to determine if the plan of action is effective or	

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	245395	A. BUILDING _____ B. WING _____	08/13/2015

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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 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 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 identified. -Multi-Vitamin with mineral 100 tablet bottle unopened with expiration date 10/14. -Calcium 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 ointment expired in 2014, the month was not readable. - ASA 81 mg 1000 tablets over the counter (OTC) expired 3/15. - ASA 81 mg OTC 500 tablets expired 7/15.	F 425	modifications need to be made.	

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F 425	Continued From page 25 - Daily Multivitamins with Minerals 100 tablets expired 10/14. - Solution of Hydrogen Peroxide (germicidal agent) 3% expired 7/15, for two bottles. - Migraine Formula (medication for headaches), 24 capsules unopened box expired 11/14. - One Daily Multivitamin with Minerals 100 tablets, unopened, expired 3/15. - Levemir Insulin (medication used to control blood sugar) dispensed 7/2/15, from the pharmacy, was opened, was not dated when opened for R9. The Levemir Insulin package insert information from Novo Nordisk dated 2/15, directed the following information on how to store the medication. "Vials: After initial use, vials should be stored in a refrigerator, never in a freezer. If refrigeration is not possible, the in-use vial can be kept unrefrigerated at room temperature, below 30°C (86°F) as long as it is kept as cool as possible and away from direct heat and light. Refrigerated LEVEMIR vials should be discarded 42 days after initial use. Unrefrigerated LEVEMIR vials should be discarded 42 days after they are first kept out of the refrigerator. LEVEMIR FlexTouch: After initial use, the LEVEMIR FlexTouch must NOT be stored in a refrigerator and must NOT be stored with the needle in place. Keep the opened (in use) LEVEMIR FlexTouch away from direct heat and light at room temperature, below 30°C (86°F). Unrefrigerated LEVEMIR FlexTouch should be discarded 42 days after they are first kept out of the refrigerator." The undated Storage of Medications policy directed "No discontinued, outdated, or	F 425		

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F 425	Continued From page 26 deteriorated medications are available for use in this facility. All such medications are destroyed..."	F 425		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility's consultant pharmacist failed to ensure monitoring for blood pressures for 3 of 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 table. -At 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 recliner. -At 10:13 a.m. R49 was again observed	F 428	It is the facility's policy to ensure that each resident's drug regimen is reviewed at least monthly by a licensed pharmacist; that the pharmacist reports any irregularities to the attending physician and the Director of Nursing and these reports are acted upon. A licensed pharmacist does review all resident records at least monthly and upon request by a physician and/or nursing staff when there is a change in a resident's condition that might be related to medications. The plan of correction for R49, R2 and R20 is the same as for all residents. The facility's policy and procedure has been reviewed and revised to ensure that each resident's drug regimen is reviewed	9/9/15

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F 428	Continued From page 27 ambulating independently gait unsteady and was redirected to sit. R49 was noted to have a flat affect. R49's diagnoses included dementia with behavioral disturbance, insomnia and dysthymic disorder obtained from admission face sheet dated 6/2/15. In addition the admission face sheet revealed an admission date of 6/1/15. Admission Minimum Data Set (MDS) dated 6/8/15, indicated R49 received both antipsychotic and antidepressant medications daily and was noted R49 had behaviors. R49's fall Care Area Assessment (CAA) dated 6/14/15, indicated R49 was at risk for falls, wandered, had impaired balance/gait and used an antidepressant. Psychotropic drug medication CAA dated 6/14/15, indicated R49 used antidepressant and antipsychotic medications. The CAA indicated R49 was at risk for psychotropic drug side effects. CAA directed staff to monitor for response and any changes in resident physical and mental status however did not indicate address when and how often to monitor for orthostatic BP's. R49's psychotropic drug use care plan dated 6/21/15, indicated R49 was at risk for adverse effects related to use of medications. The care plan directed to monitor R49 for potential side effects, orthostatic's per protocol and monitor movement disorder DISCUS per policy. R49's Physician's Orders Sheet dated 7/22/15, revealed the following orders: -Depakote (mood stabilizer) sprinkles 250 milligrams (mg) by mouth (PO) three times daily (TID) for dementia with behavioral disturbance.	F 428	at least monthly by a licensed pharmacist, that the pharmacist reports irregularities to the attending physician and DON and that reports are acted upon in order to minimize or prevent adverse consequences and identify significant risks to the extent possible. See POC for F329 regarding changes to policy/procedure for monitoring orthostatic B/P. All pharmacy consultation reports will be received by the Health Information Assistant (HIA). The Summary Report from the Pharmacy Consultant review will be given to the DON for review. Individual resident's reports will be given to resident's Resident Care Coordinators (RCCs) for review. Reports requesting physician's response will be held until next scheduled house visit unless deemed urgent, at which time it will be faxed to physician same day for review. Nursing recommendation reports will be addressed by each unit's RCC in collaboration with DON as needed. The Interdisciplinary Team (IDT) will review pharmacy recommendations if IDT review is indicated. All affected Department Heads and HIA were updated on policy/procedure revisions by 8/17/15. Consulting Pharmacist reviewed and approved policy/procedure revisions during in-house visit on 9/1/15. Medical Director will review the policy/procedure revisions during house visits on 9/9/15. The Consulting Pharmacist (CP) is	

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F 428	Continued From page 28 -Remeron (antidepressant) 30 mg PO give one daily for dysthymic disorder. -Risperdal 0.25 mg PO morning only give daily for dementia with behavioral disturbance. A review of the medical record from 6/1/15, revealed the medical record lacked documentation of orthostatic blood pressure (BPs). In addition indicated R49 had been lowered to the floor on 7/13/15, no injuries sustained however orthostatic blood pressures had not been done either at the time of the incident. During further document review, it was revealed the Consultant pharmacist's Medication Regimen monthly review had last been completed 8/3/15, with other previous reviews done 7/6/15, and 6/2/15, and had been indicated no significant clinical problems were noted. On 8/12/15, at 2:25 p.m. RN-A stated orthostatic BP's were usually done on admission and if the doctor had ordered them. RN-A verified orthostatic B/P's had not been done on admission 6/1/15, after she went through the admit evaluation. RN-A further stated R49 had refused some vital signs at the time of admission but had not been re-attempted. On 8/13/15, at 11:40 a.m. via telephone the consultant pharmacist (CP) stated he was not familiar with the facility orthostatic blood pressures (BP's) protocol and would expect the facility to check the orthostatic BP's if resident was on problematic medications. CP acknowledged if a resident was had falls would expect the facility to check the orthostatic BP's. CP indicated he would not expect the facility to	F 428	responsible for auditing residents' drug regimens monthly and providing a report of his findings as noted above. Reports include CP recommendations for physicians and others; review of policy and procedures that apply to medication management; results of audits for medication storage, dating medications, and disposition of medications; medication pass audits; completion of assessments, including orthostatic B/Ps, indicated for monitoring response to medications that pose a risk for adverse effects/consequences to the resident; and identification of trends in psychoactive medication use in the facility and GDRs. The CP will provide these reports to the QA Committee at all quarterly QA meetings. The QA Committee will review to determine if the plan of action is effective or modifications need to be made.	

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F 428	Continued From page 29 check the orthostatic BP's for R49 because she was on atypical antipsychotic medications. On 8/13/15, at 12:13 p.m. when asked what the facility protocol was for monitoring/checking orthostatic blood pressures director of nursing (DON) stated for all residents who were on psychotropic medications and were at risk for falls they were supposed to be done monthly but would be deferred if a resident was not ambulating, did not transfer self or did not reposition themselves. DON further stated when a resident was initially admitted to the facility orthostatic BP's were supposed to be done but at times it would be difficult to obtain them. -At 1:06 p.m. DON stated although it was difficult to obtain orthostatic BP's initially when residents were admitted due to adjustment and behaviors she acknowledged the nurses should have attempted later to obtain the BP's. R2's quarterly MDS dated 5/11/15, indicated R2 was admitted to the facility on 2/2/09. Admission diagnoses included depression, psychosis, 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.	F 428		

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F 428	Continued From page 30	F 428		

Physician orders dated 8/11/15, included Zyprexa 15 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 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.

On 8/13/15, at 10:57 a.m. licensed practical nurse (LPN)-B stated they do orthostatic blood pressures on admission. LPN-A further stated they may do them if physician orders it or they have an indication for it.

On 8/13/15, at 11:11 a.m. DON stated they do orthostatic blood pressures with initial admission and with fall assessments. They do not routinely do blood pressures if ambulatory, or if not symptomatic with dizziness.

On 8/13/15, at 11:40 a.m. via telephone the consultant pharmacist (CP) stated he was not familiar with the facility blood pressure protocol

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F 428	Continued From page 31	F 428		

and would expect the facility to check the orthostatic blood pressures if resident was on problematic medications. CP acknowledged if a resident had falls he would expect the facility to check the orthostatic blood pressures.

R20's quarterly MDS dated 7/17/15, indicated R20 was admitted to the facility on 6/8/10. Admission diagnoses included hypertension, depression, and schizophrenia.

The MDS dated 8/13/15, indicated R20 required two person assist with bed mobility, transfers, toilet use and dressing.

The CAA dated 8/13/15, indicated R20 did not exhibit behaviors.

The Care Plan dated 8/13/15, indicated R20 had history of depression as evidenced by display of little interest in participating with cares, therapy, activities, blunted affect, disconnect. R20 was resistive to cares, would not allow staff to provide cares/therapy at times.

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

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F 428	Continued From page 32 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. On 8/13/15, at 10:57 a.m. LPN-B stated they do orthostatic blood pressures on admission. LPN-A further stated they may do them if physician orders it or they have an indication for it. On 8/13/15, at 11:11 a.m. DON stated they do orthostatic blood pressures with initial admission 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 assist in assessing appropriateness, effectiveness, and possible adverse consequences of the medications covered by the policy." On 8/13/15, at 11:40 a.m. via telephone the consultant pharmacist (CP) stated he was not familiar with the facility blood pressure protocol and would expect the facility to check the orthostatic blood pressures if resident was on problematic medications. CP acknowledged if a resident had falls he would expect the facility to check the orthostatic blood pressures.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		9/22/15

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F 441	Continued From page 33 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure universal precautions were practiced to prevent the spread respiratory methicillin resistive staphylococcus aureus (MRSA) infection (a serious infection of the lungs, resistant to most medications) for 1 of 1 resident (R3). In addition, facility did not ensure glucometer was properly cleaned (the proper cleaning of glucometer reduces the risk of blood borne pathogens/infections) between residents for 2 of 12 residents (R53, R56). Findings include: On 8/10/15, during medication pass observation for R3, at 5:18 p.m. nursing assistant (NA)-D was observed to enter R3's room without gown, gloves or face mask. Prior to entering R3's room, licensed practical nurse (LPN)-C had put on an isolation gown, face mask and gloves because R3 had a respiratory infection. NA-D was standing in front of R3 talking. NA-D left room as LPN-C entered the room. - At 5:24 p.m. NA-D was interviewed and stated she did not have to gown or glove if she was not close to the resident. She had just brought R3 a cup of coffee. - At 5:27 p.m. LPN-C was interviewed and stated staff was expected to gown, glove and don a face mask whenever in R3's room because R3 had respiratory MRSA. Registered nurse (RN)-E was present during the interview and commented, "All staff are to gown, mask and use gloves because R3's respiratory condition. The MRSA is still infectious and still has three more days of Vancomycin (antibiotic medication)." - At 5:30 p.m. NA-D was observed delivering	F 441	It is the facility's policy to maintain an infection control program that meets the expectation to provide a safe, sanitary, and comfortable environment and to help prevent the transmission of disease and infection. The Plan of Correction for resident R3 is the same as for all residents. Infection control policies have been reviewed for Universal/Standard Precautions and Isolation Precautions as well as disinfection of glucometer between each resident use and transportation of contaminated items from rooms. Policies/procedures are current and accepted practice. The procedure has been revised to include staff training each time a resident is placed on isolation precautions in addition to existing initial and annual training. A form has been developed and placed at both nurses' stations to be used for staff education when a resident is placed on isolation precautions. A physician, DON, RCC or Charge Nurse will determine type of precautions to be used for individual residents based on illness or disease and complete this form which includes information on type of precautions to be taken, personal protective equipment (PPE) to be used, how and when to use/remove PPE and name of the person implementing the precautions. It is the Charge Nurse's responsibility to review this information with staff members who	

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CROSSROADS CARE CENTER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 35 supper food trays on the East unit. NA-D was interviewed and stated she was supposed to wear all the protective gear: gown, mask and gloves. She stated she did not wear any, because she had not gotten too close. She estimated that she was between two to three feet from R3 when she brought him some coffee. She stated R3 was not coughing or wearing a mask. On 8/12/15, at 10:00 a.m. during a random observation, LPN-A was observed sitting on the floor at R3's feet putting his white ankle socks on. LPN-A was wearing a gown, mask and gloves. A semi-transparent square tub was on the floor with blue lid next to it. The tub did not have a barrier between the square tub and contaminated the floor. LPN-A exited R3's room and set the soiled tub containing supplies for drawing blood down on the top of the table outside of R3's room without a barrier between the tabletop and container. R3 diagnosis included but not limited to bilateral MRSA Pneumonia (severe respiratory infection) in which antibiotics were ordered and diabetes. R3 was severely cognitively impaired and required assistance with dressing and bathing and assistance with ambulation. On 8/12/15, at 10:02 a.m. LPN-A was interviewed and verbalized "We were told to always gown up and wear mask and gloves. He has pneumonia MRSA. I normally do the labs on Tuesday but the blood draw was not ordered until yesterday. The evening nurses were unable to draw his blood. I normally take my whole cart (pointed at the plastic tub) into the room. So it is not in the hallway. I took the warm pack out but did not use it. I did put the container on the floor and I did sit	F 441	will have contact with the resident and resident's environment and to advise visitors and family members as well that will have contact with resident/resident's environment. Staff members will sign the form after reviewing with the Charge Nurse to affirm understanding of isolation precautions specific to each resident. Charge Nurses will monitor and reeducate staff as needed during periods of isolation precautions. Current and revised Infection Control policies/procedures will be reviewed at an in-service to be held by 09/22/15. DON will complete random audits for staff adherence to infection control policy weekly for a period of four (4) weeks, continue random audits thereafter and provide and document staff education as needed until next QA. Results of audits will be reviewed by QA Committee to determine if the plan of action is effective or modifications need to be made. DON will complete random audits of staff when any resident is placed on isolation precautions to ensure adherence to policy and procedures for specified isolation precautions. Results of audits will reviewed by QA Committee to determine if the plan of action is effective or modifications need to be made. DON will complete random audits of nurses/TMAs, provide and document staff education as needed during completion of blood glucose testing/disinfection of	

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F 441	Continued From page 36 on the floor." When questioned if the container to draw blood samples would be going from resident to resident, LPN-A further stated, "I draw all of the lab blood requests in the building." During interview on 8/13/15, at 11:11 a.m. the director of nursing (DON) stated staff learn about residents who are on isolation precautions, through report and the supplies outside the room are a definite cue to ask for information from the nurse. When a resident was admitted with new infections such as MRSA we review the precautions with staff. DON stated, "I agree if [a resident was] actively systematic-(I) expect staff to gown, glove and mask. I would gage (R3) as actively infectious." DON stated, "I don't like caddy on the floor or her on floor. (I) expect it (warm pack) to come out in bag. By setting it (warm pack) on top of caddy--now she just contaminated it." An APIC Guide to the Elimination of Methicillin-Resistant Staphylococcus aureus (MRSA) in the Long-Term Care Facility dated 2009, noted the following: "Components of Standard Precautions The prevention practices include adherence to hand hygiene standards; use of gloves, gown, mask, eye protection, or face shield as appropriate to the anticipated exposure; and safe injection practices. PPE, including gloves, masks, gowns, and eyewear, must be readily available throughout the facility to ensure that staff have the "tools" needed to comply with Standard Precautions. Standard Precautions also addresses contaminated equipment or items in the resident environment. Handle contaminated equipment in	F 441	glucometer until next QA meeting. Results of audits will reviewed by QA Committee to determine if the plan of action is effective or modifications need to be made.	

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F 441	Continued From page 37 a manner to prevent transmission of infectious agents. Proper handling includes the use of gloves and other appropriate PPE for direct contact with contaminated equipment. Heavily soiled reusable equipment must be immediately contained, bagged if appropriate, and removed to soiled utility rooms for thorough cleaning and disinfecting or sterilizing before use on another resident. (See the Environment and Equipment Cleaning and Disinfection section.) " Standard Precautions was updated in the HICPAC 2007 ' Guideline for Isolation Precautions' to include respiratory etiquette, a strategy for reducing the risk of respiratory infection spread. It included: · Educating healthcare facility staff, residents, and visitors about the risk of spread of respiratory infections in the healthcare setting · Posting signs with instructions to residents and accompanying family members or friends Methods to control respiratory secretions (covering the mouth/nose with a tissue when 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.	F 441		

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F 441	Continued From page 38	F 441		

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 delegated to the appropriate healthcare staff per facility protocols. For instance, a facility cleaning and disinfection policy or protocol will address the specific patient care staff responsibility for disinfection of equipment that may be taken from one resident to another."

The facility provided a policy titled, Isolation Precautions, Categories of, dated reviewed 3/16/15. The policy instructed staff to:
... 5. "In addition to Standard Precautions, Droplet Precautions must be implemented for a resident documented or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets [larger than 5 microns in

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F 441	Continued From page 39 size] that can be generated by the resident coughing, sneezing, talking or the performance of procedures) ...c Masks "1. In addition to standard precautions, wear a mask when working within 3 feet of the resident." Glucometer: On 8/12/15, at 7:45 a.m. RN-D was observed to perform a blood sugar check on R53. RN-D set the glucometer on the bedside table without a barrier. When RN-D was done he returned to the nurse's station and set the glucometer on desk without barrier. RN-D wiped the glucometer with a Sani-wipe for 45 seconds and put it in caddy with lancets, cotton balls and blood glucose strips. RN-D took the glucometer and caddy to the East unit. RN-D told RN-C that the glucometer was sanitized. RN-C went to perform a blood sugar check on R56. RN-C re-disinfected the glucometer as the glucometer had not been properly sanitized. RN-C wiped glucometer for one minute with Sani-wipe and then went do a blood sugar for R56 surveyor stopped nurse before contaminated glucometer was used. RN-D and RN-C were interviewed together on 8/12/15, at 10:00 a.m. They stated the policy for sanitizing a glucometer was 30 seconds. Both nurses reviewed the Sani-wipe instructions for sanitizing equipment and verified it stated to clean and allow wipe to remain in contact for two minutes. During interview on 8/13/15, at 11:11 a.m. the DON stated staff was to clean glucometers by "Sanitizing between each use with a dry time of 2 minutes."	F 441		

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F 441	Continued From page 40 Super Sani Cloth Guidelines for use dated 2014 stated, "3b. in absence of heavy soil, take a clean wipe and thoroughly wet surface for a full two (2) minutes to disinfect. 4. Allow treated surface to remain wet for a full two (2) minutes. Use additional wipe(s) if needed to assure continuous two (2) minutes wet contact time. Allow to air dry." Policy labeled Cleaning and Disinfecting Blood Glucose Meters reviewed 4/23/15, instructed staff to: "11. Use of disinfectants, antiseptics and germacides [sic] are in accordance with manufacturers' instructions and EPA or FDA label specifications to avoid harm to staff, residents and visitors and to ensure effectiveness." ... "Note: when selecting a disinfecting cleaning product, you will want to look art contact time. In other words, you want to be aware of the length of time the disinfectant must be in contact with the item being cleaned for germ/bacteria to be considered killed. Some product it may be as short as one minute, another product it may be ten (10) minutes."	F 441		
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced	F 492		9/14/15

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F 492	Continued From page 41 by: Based on interview and document review, the facility failed to ensure 1 of 1 resident (R34) who requested their bill be submitted to the intermediary for a Medicare decision was submitted and did not ensure R34 was not charged while the determination decision was pending. Findings include: Facility said in the entrance conference no one requested a demand bill. R34 was admitted to the facility on 5/28/15. R34's SNF Determination on Continued Stay dated 7/19/15, indicated family desired to have R34's bill submitted to the intermediary(Noridian) for a Medicare decision, "I want my bill submitted to the intermediary for a Medicare decision." On 8/13/15, at 2:50 p.m. RN-B stated, "I don't know which form to give so I give them both. I explained why we made the decision and tell them to call if they have any questions. I give the family a copy and put mine in a binder. I do not give a copy to the billing office. I do not understand the forms." RN-B referred the Medicare billing questions to be answered by the billing office. On 8/13/15, at 2:50 p.m. the business office manager, explained the family or resident are given a form that had information about appeals because the family had to start the process and then Stratis called the facility and ask the RCC for more information. Then Stratis made the determination about request for demand bill. "The government changed how appeals are done. It	F 492	It is the policy and procedure of the facility to submit demand bills to the intermediary/payor (National Government Services, Secure Blue or UCare) for a decision when requested by a resident or resident's Responsible Party. For R34: R34 is enrolled in SecureBlue, a MN Senior Health Option (MSHO) program which replaces Medicare Part A for residents receiving MN Medical Assistance in nursing homes. R34 received skilled services from 6/1/15 to 7/31/15. Her stay for that period was billed to SecureBlue. On 7/29/15 the facility issued a SNF Determination On Continued Stay letter to the resident in care of her daughter stating that "On 7-29-15 we reviewed your medical information and found that the services furnished, skilled therapy services, no longer qualified as covered under Medicare beginning 8-1-15. The reason is: Medicare covers medically necessary skilled rehabilitation services when needed on a daily basis. While you required skilled nursing and physical therapy from 6/1/15 to 7/31/15 medical information shows that the physical therapy services after that time are not reasonable in relation to the expected improvements in your condition. In this case, since you do not need skilled nursing on a daily basis and the therapy services are not considered reasonable and necessary, we believe your stay after	

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F 492	Continued From page 42 used to be the facility would start the appeal process but now the family has to do the initial start of the appeal. We pre-bill the month. We billed her for her monthly liability August." R34 was billed for the month(s) of the requested appeal. The business office manager and RN-B were unable to explain what the appeal process was for a resident on Medicare or who to submit the appeal to. On 8/13/15, at 3:19 p.m. the director of nurses stated facility follows Medicare guidelines and should have submitted the bill for review. A policy regarding the procedure for submission of demand bills was requested, but not provided by the facility.	F 492	7/31/15 is not covered under Medicare." The Resident Care Coordinator RN-B called the resident's daughter on 7-29-15 to inform her of this decision. This call is documented in the resident's medical record "Daughter [name] notified of Medicare denial per phone verb understanding Medicare denial form faxed to her for her signature." RN-B recalls that the daughter expressed her understanding and agreement with the facility's decision. The daughter signed the Verification of Receipt of Notice and faxed back to the facility on 7/29/15. The facility acknowledges that facility staff did not notice that the daughter had changed her mind and checked "A. I want my bill submitted to the intermediary for a Medicare decision." The facility will send a demand bill to SecureBlue and will await the decision before billing the resident further. The Accounts Receivable Manager (business office manager) will contact the daughter to see if she wants a refund for the spenddown paid for August, pending the decision by SecureBlue or if she would like to wait until she receives the decision from SecureBlue. For All Other Residents: The facility has reviewed and revised its policy and procedure for notifying residents or their Responsible Parties about non-coverage under their respective health plans and their rights to request demand bills and has updated its	

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F 492	Continued From page 43	F 492	forms to include current notification forms for Medicare A, SecureBlue and UCare. The RCCs and Accounts Receivable Manager have been re-educated as to the correct policy and procedure and correct forms to use for each payor. In the future, the Health Information Assistant (HIA) will track (log) and maintain a file of all SNF Determination Notices, review for resident/family member decision and provide copies to the Accounts Receivable Manager. The Accounts Receivable Manager will review and log same and ensure that demand bills are sent when requested, notify the HIA when a demand bill has been submitted and of the payor's decision when received. The Administrator will audit the file/log maintained by the HIA monthly to assure the policy/procedure is being followed. Results of audits will be reviewed at the next Quarterly QA meeting to determine if the plan of action is effective or modifications need to be made.	

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	245395	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/11/2015**

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

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Crossroads Care Center was constructed as follows: The original building was constructed in 1953, is one-story in height, has a full basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1968 Addition is one-story in height, has a full basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The facility has smoke detection in the corridors and spaces open to the corridors, which are monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 40 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029	NFPA 101 LIFE SAFETY CODE STANDARD	K 029		8/11/15

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K 029 SS=D	Continued From page 2 One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 15 out of 50 residents. Findings include: On facility tour between 9:15 AM and 11:00 AM on 08/11/2015, observation revealed that the following was found: 1. The door to storage room # C-9 (over 50 sq. ft.) has a kick down hold open device. This door was propped open at the time of inspection. This deficient practice was confirmed by the Facility Maintenance Director (DV) at the time of discovery.	K 029	The kick down device was removed on 8/11/15. Staff in dietary and housekeeping who use this storage room were reminded that the door is to be kept closed at all times when not in use and that doors to storage areas may not be held open with any kind of door stop except when staff are present unloading freight or getting supplies to take to work areas. The Maintenance Supervisor will be responsible for correction and monitoring to prevent a reoccurrence of the deficiency and will report to the supervisors of staff who use this storage room (housekeeping and dietary) if further interventions need to be taken.	

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K 076 K 076 SS=D	Continued From page 3 NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation, the facility was storing medical gas cylinders in a manner not in conformance with NFPA 99 (1999 edition) Chapter 4, Section 4-3.1.1.1. This deficient practice could adversely affect residents, staff or visitors in the vicinity of the Oxygen Storage Room. FINDINGS INCLUDE: On facility tour between 9:00 AM and 11:00 AM on 08/11/2015, observation revealed eleven (11) empty oxygen cylinders stored inside of the Main Oxygen Storage Room. These cylinders were stored on the floor surface, in an upright position, and were not secured and located to prevent tipping/falling. This free-standing storage arrangement was not in conformance with NFPA 99 (1999), Chapter 4, Section 4-3.1.1.1 and Chapter 8, Section 8-3.1.1.	K 076 K 076	The Maintenance Supervisor and the Director of Nursing rearranged the oxygen storeroom and secured the empty cylinders in holders on 8/11/15. Nursing staff were re-educated by the Director of Nursing on 8/11/15 as to regulation and policy/procedure for safe storage of oxygen tanks. The Director of Nursing will be responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Maintenance Supervisor will audit for compliance daily for 4 weeks, then weekly going forward to assure compliance.	8/11/15

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	245395	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/11/2015**

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K 076	Continued From page 4 This finding was confirmed with the facility director (DV) at the time of discovery.	K 076		

MINNESOTA MDH DEPARTMENT OF HEALTH

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

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

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

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

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00407	A. BUILDING: _____ B. WING _____	08/13/2015

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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

Electronically Signed | 09/07/15

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 8/10/15, through 8/13/15 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control;	21390		9/3/15

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21390	Continued From page 2 E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure universal precautions were practiced to prevent the spread respiratory methicillin resistive staphylococcus aureus (MRSA) infection (a serious infection of the lungs, resistant to most medications) for 1 of 1 resident (R3). This practice had the potential to affect all 39 residents who resided at the facility, staff and visitors. In addition, facility did not ensure glucometer was properly cleaned (the proper cleaning of glucometer reduces the risk of blood borne pathogens/infections) between residents for 2 of 12 residents (R53, R56). Findings include: On 8/10/15, during medication pass observation for R3, at 5:18 p.m. nursing assistant (NA)-D was observed to enter R3's room without gown, gloves or face mask. Prior to entering R3's room,	21390	Corrected	

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licensed practical nurse (LPN)-C had put on an isolation gown, face mask and gloves because R3 had a respiratory infection. NA-D was standing in front of R3 talking. NA-D left room as LPN-C entered the room.
- At 5:24 p.m. NA-D was interviewed and stated she did not have to gown or glove if she was not close to the resident. She had just brought R3 a cup of coffee.
- At 5:27 p.m. LPN-C was interviewed and stated staff was expected to gown, glove and don a face mask whenever in R3's room because R3 had respiratory MRSA. Registered nurse (RN)-E was present during the interview and commented, "All staff are to gown, mask and use gloves because R3's respiratory condition. The MRSA is still infectious and still has three more days of Vancomycin (antibiotic medication)."
- At 5:30 p.m. NA-D was observed delivering supper food trays on the East unit. NA-D was interviewed and stated she was supposed to wear all the protective gear: gown, mask and gloves. She stated she did not wear any, because she had not gotten too close. She estimated that she was between two to three feet from R3 when she brought him some coffee. She stated R3 was not coughing or wearing a mask.

On 8/12/15, at 10:00 a.m. during a random observation, LPN-A was observed sitting on the floor at R3's feet putting his white ankle socks on. LPN-A was wearing a gown, mask and gloves. A semi-transparent square tub was on the floor with blue lid next to it. The tub did not have a barrier between the square tub and contaminated the floor. LPN-A exited R3's room and set the soiled tub containing supplies for drawing blood down on the top of the table outside of R3's room without a barrier between the tabletop and container.

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21390	Continued From page 4 R3 diagnosis included but not limited to bilateral MRSA Pneumonia (severe respiratory infection) in which antibiotics were ordered and diabetes. R3 was severely cognitively impaired and required assistance with dressing and bathing and assistance with ambulation. On 8/12/15, at 10:02 a.m. LPN-A was interviewed and verbalized "We were told to always gown up and wear mask and gloves. He has pneumonia MRSA. I normally do the labs on Tuesday but the blood draw was not ordered until yesterday. The evening nurses were unable to draw his blood. I normally take my whole cart (pointed at the plastic tub) into the room. So it is not in the hallway. I took the warm pack out but did not use it. I did put the container on the floor and I did sit on the floor." When questioned if the container to draw blood samples would be going from resident to resident, LPN-A further stated, "I draw all of the lab blood requests in the building." During interview on 8/13/15, at 11:11 a.m. the director of nursing (DON) stated staff learn about residents who are on isolation precautions, through report and the supplies outside the room are a definite cue to ask for information from the nurse. When a resident was admitted with new infections such as MRSA we review the precautions with staff. DON stated, "I agree if [a resident was] actively systematic-(I) expect staff to gown, glove and mask. I would gage (R3) as actively infectious." DON stated, "I don't like caddy on the floor or her on floor. (I) expect it (warm pack) to come out in bag. By setting it (warm pack) on top of caddy--now she just contaminated it." An APIC Guide to the Elimination of	21390		

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Methicillin-Resistant Staphylococcus aureus (MRSA) in the Long-Term Care Facility dated 2009, noted the following:
"Components of Standard Precautions
The prevention practices include adherence to hand hygiene standards; use of gloves, gown, mask, eye protection, or face shield as appropriate to the anticipated exposure; and safe injection practices. PPE, including gloves, masks, gowns, and eyewear, must be readily available throughout the facility to ensure that staff have the "tools" needed to comply with Standard Precautions.

Standard Precautions also addresses contaminated equipment or items in the resident environment. Handle contaminated equipment in a manner to prevent transmission of infectious agents. Proper handling includes the use of gloves and other appropriate PPE for direct contact with contaminated equipment. Heavily soiled reusable equipment must be immediately contained, bagged if appropriate, and removed to soiled utility rooms for thorough cleaning and disinfecting or sterilizing before use on another resident. (See the Environment and Equipment Cleaning and Disinfection section.) "

Standard Precautions was updated in the HICPAC 2007 ' Guideline for Isolation Precautions' to include respiratory etiquette, a strategy for reducing the risk of respiratory infection spread. It included:
· Educating healthcare facility staff, residents, and visitors about the risk of spread of respiratory infections in the healthcare setting
· Posting signs with instructions to residents and accompanying family members or friends
Methods to control respiratory secretions (covering the mouth/nose with a tissue when

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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

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21390	Continued From page 7 delegated to the appropriate healthcare staff per facility protocols. For instance, a facility cleaning and disinfection policy or protocol will address the specific patient care staff responsibility for disinfection of equipment that may be taken from one resident to another." The facility provided a policy titled, Isolation Precautions, Categories of, dated reviewed 3/16/15. The policy instructed staff to: ... 5. "In addition to Standard Precautions, Droplet Precautions must be implemented for a resident documented or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets [larger than 5 microns in size] that can be generated by the resident coughing, sneezing, talking or the performance of procedures) ...c Masks "1. In addition to standard precautions, wear a mask when working within 3 feet of the resident." Glucometer: On 8/12/15, at 7:45 a.m. RN-D was observed to perform a blood sugar check on R53. RN-D set the glucometer on the bedside table without a barrier. When RN-D was done he returned to the nurse's station and set the glucometer on desk without barrier. RN-D wiped the glucometer with a Sani-wipe for 45 seconds and put it in caddy with lancets, cotton balls and blood glucose strips. RN-D took the glucometer and caddy to the East unit. RN-D told RN-C that the glucometer was sanitized. RN-C went to perform a blood sugar check on R56. RN-C re-disinfected the glucometer as the glucometer had not been properly sanitized. RN-C wiped glucometer for one minute with Sani-wipe and then went do a blood sugar for R56 surveyor stopped nurse before contaminated glucometer was used.	21390		

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21390	Continued From page 8 RN-D and RN-C were interviewed together on 8/12/15, at 10:00 a.m. They stated the policy for sanitizing a glucometer was 30 seconds. Both nurses reviewed the Sani-wipe instructions for sanitizing equipment and verified it stated to clean and allow wipe to remain in contact for two minutes. During interview on 8/13/15, at 11:11 a.m. the DON stated staff was to clean glucometers by "Sanitizing between each use with a dry time of 2 minutes." Super Sani Cloth Guidelines for use dated 2014 stated, "3b. in absence of heavy soil, take a clean wipe and thoroughly wet surface for a full two (2) minutes to disinfect. 4. Allow treated surface to remain wet for a full two (2) minutes. Use additional wipe(s) if needed to assure continuous two (2) minutes wet contact time. Allow to air dry." Policy labeled Cleaning and Disinfecting Blood Glucose Meters reviewed 4/23/15, instructed staff to: "11. Use of disinfectants, antiseptics and germacides [sic] are in accordance with manufacturers' instructions and EPA or FDA label specifications to avoid harm to staff, residents and visitors and to ensure effectiveness." ... "Note: when selecting a disinfecting cleaning product, you will want to look art contact time. In other words, you want to be aware of the length of time the disinfectant must be in contact with the item being cleaned for germ/bacteria to be considered killed. Some product it may be as short as one minute, another product it may be ten (10) minutes."	21390		

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21390	Continued From page 9 SUGGESTED METHOD FOR CORRECTION: The director of nursing could review and revise the policies and procedures related to infection control surveillance. She or designee could provide education to all involved staff. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis 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.	21426		9/3/15

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CROSSROADS CARE CENTER	965 MCMILLAN STREET WORTHINGTON, MN 56187

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21426	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 3 residents (R53, R56, R57) and 2 of 5 recently hired employees had Tuberculin Skin Test (TST) induration interpretation and Tuberculosis (TB) symptom screening per TB Screening State Regulations. Findings included: R53 was admitted to the facility on 7/20/15. 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 "Negative" interpretation on 7/27/15, however no induration in millimeter (mm) was indicated. R56 was admitted to the facility on 7/22/15. R56's medical record indicted he received the first step of her TST on 7/23/15, and the results were read as 0 mm with a "Negative" interpretation of 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. 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.	21426	Corrected	

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21426	Continued From page 11 Employees A review of nursing assistant (NA)-C file revealed a hire date of 6/22/15. During review of the Employee Tuberculosis symptom screening form it was revealed the form had not been complete and was blank yet at the back of it revealed NA-C had received the first step TST on 6/22/15, and results were read as 0 mm with a "Negative" interpretation of reading on 6/24/15, and the second step TST on 8/7/15, results were read on 8/9/15, as 0 mm with a negative interpretation. A review of maintenance staff (M)-A file revealed a hire date of 5/5/15. The Employee Tuberculosis symptom screening form indicated it had been completed on 5/4/15. During further review it was revealed M-A had received the first step TST on 5/4/15, and results were read as 0 mm with a "Negative" interpretation of reading on 5/6/15, and the second step TST on 5/18/15, results were read on 5/21/15, with a "negative" interpretation however no induration was indicated. On 8/11/15, at 1:53 p.m. when asked if nurses were supposed to indicate the date when assessment had been completed registered nurse (RN)-A stated " absolutely. " On 8/13/15, at 10:31 a.m. RN-B verified R53's first step TST had no induration documented. On 8/13/15, at 1:06 p.m. the director of nursing (DON) acknowledged the TST reading for R57 should have both the induration and interpretation. In addition acknowledged the TB symptom screening was supposed to be completed for the employees and all records were supposed to be dated when completed. -At 1:32 p.m. the RN -B verified NA-C TB	21426		

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21426	Continued From page 12 symptom screening form had not been completed and M-A second step 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..." SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice staff responsible for TB control on the protocol from MDH. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual,	21530		9/3/15

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21530	Continued From page 13 Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility's consultant pharmacist failed to ensure monitoring for blood pressures for 3 of	21530	Corrected	

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21530	Continued From page 14 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 table. -At 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 recliner. -At 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. R49's diagnoses included dementia with behavioral disturbance, insomnia and dysthymic disorder obtained from admission face sheet dated 6/2/15. In addition the admission face sheet revealed an admission date of 6/1/15. Admission Minimum Data Set (MDS) dated 6/8/15, indicated R49 received both antipsychotic and antidepressant medications daily and was noted R49 had behaviors. R49's fall Care Area Assessment (CAA) dated 6/14/15, indicated R49 was at risk for falls, wandered, had impaired balance/gait and used an antidepressant. Psychotropic drug medication CAA dated 6/14/15, indicated R49 used antidepressant and antipsychotic medications. The CAA indicated R49 was at risk for psychotropic drug side effects. CAA directed staff to monitor for response and any changes in resident physical and mental status however did	21530		

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21530	Continued From page 15 not indicate address when and how often to monitor for orthostatic BP's. R49's psychotropic drug use care plan dated 6/21/15, indicated R49 was at risk for adverse effects related to use of medications. The care plan directed to monitor R49 for potential side effects, orthostatic's per protocol and monitor movement disorder DISCUS per policy. R49's Physician's Orders Sheet dated 7/22/15, revealed the following orders: -Depakote (mood stabilizer) sprinkles 250 milligrams (mg) by mouth (PO) three times daily (TID) for dementia with behavioral disturbance. -Remeron (antidepressant) 30 mg PO give one daily for dysthymic disorder. -Risperdal 0.25 mg PO morning only give daily for dementia with behavioral disturbance. A review of the medical record from 6/1/15, revealed the medical record lacked documentation of orthostatic blood pressure (BPs). In addition indicated R49 had been lowered to the floor on 7/13/15, no injuries sustained however orthostatic blood pressures had not been done either at the time of the incident. During further document review, it was revealed the Consultant pharmacist's Medication Regimen monthly review had last been completed 8/3/15, with other previous reviews done 7/6/15, and 6/2/15, and had been indicated no significant clinical problems were noted. On 8/12/15, at 2:25 p.m. RN-A stated orthostatic BP's were usually done on admission and if the doctor had ordered them. RN-A verified orthostatic B/P's had not been done on admission	21530		

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21530	Continued From page 16 6/1/15, after she went through the admit evaluation. RN-A further stated R49 had refused some vital signs at the time of admission but had not been re-attempted. On 8/13/15, at 11:40 a.m. via telephone the consultant pharmacist (CP) stated he was not familiar with the facility orthostatic blood pressures (BP's) protocol and would expect the facility to check the orthostatic BP's if resident was on problematic medications. CP acknowledged if a resident was had falls would expect the facility to check the orthostatic BP's. CP indicated he would not expect the facility to check the orthostatic BP's for R49 because she was on atypical antipsychotic medications. On 8/13/15, at 12:13 p.m. when asked what the facility protocol was for monitoring/checking orthostatic blood pressures director of nursing (DON) stated for all residents who were on psychotropic medications and were at risk for falls they were supposed to be done monthly but would be deferred if a resident was not ambulating, did not transfer self or did not reposition themselves. DON further stated when a resident was initially admitted to the facility orthostatic BP's were supposed to be done but at times it would be difficult to obtain them. -At 1:06 p.m. DON stated although it was difficult to obtain orthostatic BP's initially when residents were admitted due to adjustment and behaviors she acknowledged the nurses should have attempted later to obtain the BP's. R2's quarterly MDS dated 5/11/15, indicated R2 was admitted to the facility on 2/2/09. Admission diagnoses included depression, psychosis,	21530		

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21530	Continued From page 17 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 dated 8/11/15, included Zyprexa 15 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 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.	21530		

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21530	Continued From page 18 On 8/13/15, at 10:57 a.m. licensed practical nurse (LPN)-B stated they do orthostatic blood pressures on admission. LPN-A further stated they may do them if physician orders it or they have an indication for it. On 8/13/15, at 11:11 a.m. DON stated they do orthostatic blood pressures with initial admission and with fall assessments. They do not routinely do blood pressures if ambulatory, or if not symptomatic with dizziness. On 8/13/15, at 11:40 a.m. via telephone the consultant pharmacist (CP) stated he was not familiar with the facility blood pressure protocol and would expect the facility to check the orthostatic blood pressures if resident was on problematic medications. CP acknowledged if a resident had falls he would expect the facility to check the orthostatic blood pressures. R20's quarterly MDS dated 7/17/15, indicated R20 was admitted to the facility on 6/8/10. Admission diagnoses included hypertension, depression, and schizophrenia. The MDS dated 8/13/15, indicated R20 required two person assist with bed mobility, transfers, toilet use and dressing. The CAA dated 8/13/15, indicated R20 did not exhibit behaviors. The Care Plan dated 8/13/15, indicated R20 had history of depression as evidenced by display of little interest in participating with cares, therapy, activities, blunted affect, disconnect. R20 was resistive to cares, would not allow staff to provide cares/therapy at times.	21530		

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21530	Continued From page 19 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. On 8/13/15, at 10:57 a.m. LPN-B stated they do orthostatic blood pressures on admission. LPN-A further stated they may do them if physician orders it or they have an indication for it. On 8/13/15, at 11:11 a.m. DON stated they do orthostatic blood pressures with initial admission 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 assist in assessing appropriateness, effectiveness, and possible adverse consequences of the medications covered by the	21530		

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21530	Continued From page 20 policy." On 8/13/15, at 11:40 a.m. via telephone the consultant pharmacist (CP) stated he was not familiar with the facility blood pressure protocol and would expect the facility to check the orthostatic blood pressures if resident was on problematic medications. CP acknowledged if a resident had falls he would expect the facility to check the orthostatic blood pressures. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or desigee could work with the medical director and consultant pharmacist to ensure to inform the facilty medication irregularities. The DON could ensure the staff were educated on the importance of medication irregularities.The DON or designee could randomly audit resident records to ensure adequate monitoring, parameters and documentation was in place. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the	21540		9/3/15

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21540	Continued From page 21 matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 3 of 6 residents (R49, R2, R20) had adequate monitoring for psychotropic 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 table. -At 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 recliner. -At 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. R49's diagnoses included dementia with behavioral disturbance, insomnia and dysthymic disorder obtained from admission face sheet dated 6/2/15. In addition the admission face sheet	21540	Corrected	

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21540	Continued From page 22	21540		

revealed an admission date of 6/1/15. Admission MDS dated 6/8/15, indicated R49 received both antipsychotic and antidepressant medications daily and was noted R49 had behaviors.

R49's fall Care Area Assessment (CAA) dated 6/14/15, indicated R49 was at risk for falls, wandered, had impaired balance/gait and used an antidepressant. Psychotropic drug medication CAA dated 6/14/15, indicated R49 used antidepressant and antipsychotic medications. The CAA indicated R49 was at risk for psychotropic drug side effects. CAA directed staff to monitor for response and any changes in resident physical and mental status however did not indicate address when and how often to monitor for orthostatic BP's.

R49's psychotropic drug use care plan dated 6/21/15, indicated R49 was at risk for adverse effects related to use of medications. The care plan directed to monitor R49 for potential side effects, orthostatic's per protocol and monitor movement disorder DISCUS per policy.

R49's Physician's Orders Sheet dated 7/22/15, revealed the following orders:
-Depakote (mood stabilizer) sprinkles 250 milligrams (mg) by mouth (PO) three times daily (TID) for dementia with behavioral disturbance.
-Remeron (antidepressant) 30 mg PO give one daily for dysthymic disorder.
-Risperdal 0.25 mg PO morning only give daily for dementia with behavioral disturbance.

A review of the medical record from 6/1/15, revealed the medical record lacked documentation of orthostatic blood pressure (BPs). In addition indicated R49 had been lowered to the floor on 7/13/15, no injuries

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21540	Continued From page 23 sustained however orthostatic blood pressures had not been done either at the time of the incident. On 8/12/15, at 2:25 p.m. RN-A stated orthostatic BP's were usually done on admission and if the doctor had ordered them. RN-A verified orthostatic B/P's had not been done on admission 6/1/15, after she went through the admit evaluation. RN-A further stated R49 had refused some vital signs at the time of admission but had not been re-attempted. On 8/13/15, at 12:13 p.m. when asked what the facility protocol was for monitoring/checking orthostatic blood pressures DON stated for all residents who were on psychotropic medications and were at risk for falls they were supposed to be done monthly but would be deferred if a resident was not ambulating, did not transfer self or did not reposition themselves. DON further stated when a resident was initially admitted to the facility orthostatic BP's were supposed to be done but at times it would be difficult to obtain them. -At 1:06 p.m. DON stated although it was difficult to obtain orthostatic BP's initially when residents were admitted due to adjustment and behaviors she acknowledged the nurses should have attempted later to obtain the BP's. DON further stated the resident care coordinators were responsible for making sure the DISCUS assessment were accurately completed and the CP should have caught it but thought the assessment had been done prior to the current CP as the facility had switched pharmacists. R2's quarterly MDS dated 5/11/15, indicated R2 was admitted to the facility on 2/2/09. Admission	21540		

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21540	Continued From page 24 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. R2's physician orders dated 8/11/15, included Zyprexa (antipsychotic) 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. 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.	21540		

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21540	Continued From page 25 R20's quarterly MDS dated 7/17/15, indicated R20 was admitted to the facility on 6/8/10. Admission diagnoses included hypertension, depression, and schizophrenia. R20's quarterly Minimum Data Set (MDS) dated 8/13/15, indicated R20 received both antipsychotic and antidepressant medications daily and was noted R20 refused cares. R20's CAA dated 8/13/15, indicated R20 did not exhibit behaviors. In addition care Plan dated 8/13/15, indicated R20 had history of depression as evidenced by display of little interest in participating with cares, therapy, activities, blunted affect, disconnect. R20 was resistive to cares, would not allow staff to provide cares/therapy at times. R20's physician orders dated 8/12/15, indicated R20 received Risperdal 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. 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.	21540		

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21540	Continued From page 26 On 8/13/15, at 10:57 a.m. licensed practical nurse (LPN)-B stated they do orthostatic blood pressures on admission. LPN-A further stated they may do them if physician orders it or they have an indication for it. On 8/13/15, at 11:11 a.m. DON stated they do orthostatic blood pressures with initial admission 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 assist in assessing appropriateness, effectiveness, and possible adverse consequences of the medications covered by the policy." SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or desigee could work with the medical director and consultant pharmacist to ensure medications were reviewed for appropriate interventions, monitoring and parameters for use. The DON could ensure the staff were educated on the importance of monitoring for unnecessary medications.The DON or designee could randomly audit resident records to ensure adequate monitoring, parameters and documentation was in place. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21620	MN Rule 4658.1345 Labeling of Drugs	21620		9/3/15

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21620	Continued From page 27 Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Citation Text for Tag 0425, Regulation FF09 Jares, Magdalene Based on observation, interview and document review, the facility failed to ensure expired medications were stored in 2 of 2 medication units. In addition failed to ensure medications with a short shelf life were dated when opened. Findings include: South Unit On 8/13/15, at 10:42 a.m. completed the medication tour to the medication cart with licensed practical nurse (LPN)-B and registered nurse (RN)-B who provided access to the cart during the tour the following were identified: -Low dose safety coated Aspirin (a mild analgesic) 81 milligrams (mg) 500 bottle with expiration date 7/15. -Enteric coated Aspirin 81 mg analgesic 1000 house stock bottle with expiration date 3/15. -Benadryl (anti-histamine) 25 mg 24 tablet boxes with 22 left with expiration date 1/15. -Serevent Diskus (breathing medication) 50 micrograms (mcg) for R2 not dated when opened. LPN-B acknowledged should that have been dated when opened. -Multi-vitamin with minerals 100 tablets with expiration date 10/14. -Advair Diskus (breathing medication) aerosol 250/50 mcg one puff two times daily was undated for R15.	21620	Corrected	

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21620	Continued From page 28 LPN-B verified all medications were either not dated when opened and stated both residents received the inhalers. In addition verified the expired medications stated they were supposed to be dated when opened and expired medications were not supposed to be stored in the medication cart. LPN-B stated the night nurse was responsible for making sure On 8/13/15, at 10:51 a.m. the director of nursing (DON) stated inhalers were supposed to be dated when opened and the nurse were supposed to look at the labels and expired medications were not supposed to be in the cart. When asked who was responsible for making sure expired medications and medications were date 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 1 month after you open the foil pouch or when the counter reads 0, whichever comes first." East unit	21620		

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21620	Continued From page 29 On 8/13/15, at 10:56 a.m. the medication storage tour as completed with RN- E. During the tour the following were identified and RN-E stated expired medications would be sent to the pharmacy or destroyed. -Multi-Vitamin with mineral 100 tablet bottle unopened with expiration date 10/14. -Calcium Carbonate (promote bone growth) 1250 mg box with 100 tablets 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: - 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 ointment expired in 2014, the month was not readable. - ASA 81 mg 1000 tablets over the counter (OTC) expired 3/15. - ASA 81 mg OTC 500 tablets expired 7/15. - Daily Multivitamins with Minerals 100 tablets expired 10/14. - Solution of Hydrogen Peroxide (germicidal agent) 3% expired 7/15, for two bottles. - Migraine Formula (medication for headaches), 24 capsules unopened box expired 11/14. - One Daily Multivitamin with Minerals 100 tablets, unopened, expired 3/15. - Levemir Insulin (medication used to control blood sugar) dispensed 7/2/15, from the pharmacy, was opened, was not dated when opened for R9. The Levemir Insulin package insert information	21620		

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21620	Continued From page 30 from Novo Nordisk dated 2/15, directed the following information on how to store the medication. "Vials: After initial use, vials should be stored in a refrigerator, never in a freezer. If refrigeration is not possible, the in-use vial can be kept unrefrigerated at room temperature, below 30°C (86°F) as long as it is kept as cool as possible and away from direct heat and light. Refrigerated LEVEMIR vials should be discarded 42 days after initial use. Unrefrigerated LEVEMIR vials should be discarded 42 days after they are first kept out of the refrigerator. LEVEMIR FlexTouch: After initial use, the LEVEMIR FlexTouch must NOT be stored in a refrigerator and must NOT be stored with the needle in place. Keep the opened (in use) LEVEMIR FlexTouch away from direct heat and light at room temperature, below 30°C (86°F). Unrefrigerated LEVEMIR FlexTouch should be discarded 42 days after they are first kept out of the refrigerator." The undated Storage of Medications policy directed "No discontinued, outdated, or deteriorated medications are available for use in this facility. All such medications are destroyed..." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of labeling medications properly and discarding expired medications. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one	21620		

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21620	Continued From page 31 (21) days.	21620		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interviews and document review the facility failed to immediately report to administrator and State agency (SA) and thoroughly investigate an allegation of an injury of unknown origin 1 of 4 residents (R33) reviewed for abuse prohibition. Findings include: The facility's Abuse Prevention Program: revised 4/16/08, informed staff to do the following: "Investigation: All incidents, accidents, injuries, changes of condition, resident to resident altercations and actual or suspected abuse reports or allegations of actual or suspected abuse will be taken seriously and thoroughly investigated. Investigation is a process used to identify what happened. Investigation begins immediately after incidents, mistreatment, exploitation or misappropriation of property	21995	Corrected	9/3/15

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21995	Continued From page 32	21995		

occurs or a report of same is received."
"REPORTING AND RESPONSE: All employees are mandated reporters. Staff is expected to report incidents, accidents, injuries (including injuries of unknown origin), medication errors, change of condition, resident to resident altercations and actual or suspected abuse to the Charge Nurse on duty or the Director of Nursing, Social Service Director and the Administrator. Accidents involving injury, unexplained injuries and actual or suspected abuse, neglect, Mistreatment, exploitation and misappropriation of property will be reported to the Minnesota Department of Health (online) within 24 hours."

Another policy titled Delegation of Authority for Immediate Reporting of Actual or Alleged Mistreatment, Neglect or Abuse in Absence of Administrator dated 6/13/15, instructed staff to notify the administrator immediately when actual or suspected abuse occurs."
Review of the Resident Incident Reports from 5/1/15, going forward noted the following:
R33 had a Resident Incident Report dated 5/24/15. The incident alleged R33 had sustained an injury of unknown origin in the groin. The time of incident was marked as a.m. The section "Describe EXACTLY what happened" reported bruise found during AM cares-2 bruises noted on left inner thigh 1 measures 1 cm. [centimeter] x 2 cm there [sic] other measures 2 cm x 2 cm." The section noted a body diagram which had a circle drawn on left inner thigh, near the groin. The back page of Resident Incident Report had a box which indicated R33 had an unexplained injury which was marked "Yes." The form depicted R33 as being 'confused' and 'totally disoriented.' The form went on to note that social services notified on 5/26/15, at 7:00 a.m. The director of nursing (DON) was notified on 5/26/15, at 8:30 a.m. (two

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21995	Continued From page 33	21995		

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 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 residents are protected from potential retaliation

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21995	Continued From page 34 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 CORRECTION: Twenty One (21) days.	21995		