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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: X0SE

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00470

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245251**

2.STATE VENDOR OR MEDICAID NO.
(L2) **861347800**

3. NAME AND ADDRESS OF FACILITY
(L3) **RIVERVIEW HOSPITAL & NURSING HOME**
(L4) **323 SOUTH MINNESOTA**
(L5) **CROOKSTON, MN** (L6) **56716**

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 **12/11/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **24** (L18)
13.Total Certified Beds **24** (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:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	24			
(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 :
Lyla Burkman, Unit Supervisor 01/11/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 01/11/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1982
(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
12/04/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245251

January 11, 2018

Mr. Paul Gaebe, Administrator
Riverview Hospital and Nursing Home
323 South Minnesota
Crookston, MN 56716

Dear Mr. Gaebe:

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

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

Effective December 14, 2017 the above facility is recommended for:

24 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 24 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 11, 2018

Mr. Paul Gaebe, Administrator
Riverview Hospital and Nursing Home
323 South Minnesota
Crookston, MN 56716

RE: Project Number S5251039

Dear Mr. Gaebe:

On November 7, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 26, 2017. This survey found the most serious deficiencies to widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 11, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 18, 2017 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 October 26, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 14, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 26, 2017, effective December 14, 2017 and therefore remedies outlined in our letter to you dated November 7, 2017, 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: X0SE

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00470

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(L1) **245251**
2.STATE VENDOR OR MEDICAID NO.
(L2) **861347800**

3. NAME AND ADDRESS OF FACILITY
(L3) **RIVERVIEW HOSPITAL & NURSING HOME**
(L4) **323 SOUTH MINNESOTA**
(L5) **CROOKSTON, MN** (L6) **56716**

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 **10/26/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	24			
(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Kathie Killoran, HFE-NE II 11/27/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Enforcement Specialist 11/29/2017 (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)

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3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
08/01/1982
(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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 7, 2017

Mr. Paul Gaebe, Administrator
Riverview Hospital & Nursing Home
323 South Minnesota Street
Crookston, MN 56716

RE: Project Number S5251039

Dear Mr. Gaebe:

On October 26, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 5, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 5, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 26, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 26, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this electronic notice.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

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
	245251	A. BUILDING _____ B. WING _____	10/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	**323 SOUTH MINNESOTA CROOKSTON, MN 56716**

(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 On October 23, 24, 25, and 26, 2017, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with requirements at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's electronic Plan of Correction (ePoC) 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.	F 000		
F 334 SS=D	INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS CFR(s): 483.80(d)(1)(2) (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;	F 334		11/22/17

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

Electronically Signed | 11/17/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	10/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

(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 334	Continued From page 1 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	10/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	323 SOUTH MINNESOTA CROOKSTON, MN 56716

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F 334	Continued From page 2 (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure pneumococcal immunizations were administered or refusal or contraindications to immunizations were documented for 3 of 5 residents (R7, R8, R19) reviewed for immunizations. In addition, the facility's policy for immunization/vaccination did not reflect the current standard of immunization for pneumonia. Findings include: The Center for Disease Control and Prevention (CDC) recommendations for pneumococcal vaccines include: one dose of pneumococcal conjugate vaccine (PCV13) is recommended for all adults aged 65 or older who have not previously received the vaccine. A dose of pneumococcal polysaccharide vaccine 23 (PPSV23) should be given at least one year later. For adults 65 years or older who have already received one or more doses of PPSV23 prior to age 65, the dose of PCV13 should be given at least one year after receiving the most recent dose of PPSV23 and an additional dose of	F 334	Facility timely submits this response and plan of correction pursuant to Federal and State law requirements. This response and plan of correction are not admissions, or an agreement, that a deficiency exists or that the statement of a deficiency was correctly cited or factually based and it is not to be construed as an admission against the interest of the facility, the administrator, or any employees, agents, or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same. R8's pneumococcal immunization (PPSV23), was administered on 10/29/2017, after verification of history with Minnesota Immunization Information Connection, (MIIC), and obtaining verbal consent from responsible party. R7's pneumococcal immunization (PPSV23), was administered on 10/27/2017, after verification of history with MIIC and obtaining verbal consent from responsible party.	

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F 334	Continued From page 3 PPSV23 is recommend 1 year after receiving PCV13 and 5 years after receiving the last dose of PPSV23. R7's RVCC Immunization Record indicated R7 received a pneumococcal immunization on 8/17/16, at the age of 73. The record did not identify the type of pneumococcal immunization provided. R7's Minnesota Immunization Information Connection (MIIC) history indicated R7 had not received any previous or additional pneumococcal immunizations. P8's MIIC history indicated R8 received PCV13 on 6/23/16, at the age of 88. R8's medical record lacked documented evidence PPSV23 had been offered or administered. P19's RVCC Immunization Record indicated R19 received PPSV23 on 3/7/11, at the age of 61. The record also indicated R19 received PCV13 on 4/7/16. The record lacked documented evidence the subsequent required dose of PPSV23 had been offered or administered. On 10/26/17, at 10:50 a.m. registered nurse (RN)-B confirmed R19 was not offered PPSV23 after 4/7/17, as required. --at 11:12 a.m. RN-B indicated R7 was given PCV13 on 8/17/16. She confirmed R7 had not received any further pneumococcal immunizations and should have received PPSV23 after 8/17/17. --at 11:14 a.m. RN-B obtained the MIIC history report for R8 and confirmed she should have	F 334	R19's pneumococcal immunization (PPSV23), was administered on 10/27/2017, after verification of history with MIIC and obtaining verbal consent from responsible party. The Policy for pneumococcal immunizations was changed to reflect Centers for Disease Control, (CDC), recommendations on 11/15/2017. All resident's immunization records will be reviewed following CDC guidelines with consents received and any needed immunizations administered by 11/22/2017. This process for compliance with immunizations has been reviewed at the Interdisciplinary Team, (IDT), meeting on November 21, 2017, as part of the facility QAPI process. The IDT Team meets on a weekly basis. Facility will also continue to monitor for compliance through reporting at quarterly QA, (Quality Assurance), meetings.	

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F 334	Continued From page 4 received PPSV23 in June of 2017. On 10/26/17, at 11:39 a.m. the director of nursing confirmed pneumococcal immunizations should have been given per the CDC guidelines. The Immunization/Vaccination (Resident) policy dated 11/16/16, indicated pneumococcal immunization would be offered on admission and every 5 years thereafter. The policy did not identify requirements for PPSV23 versus PCV13 immunizations.	F 334		
F 425 SS=D	PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH CFR(s): 483.45(a)(b)(1) (a) Procedures. 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. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) 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 procedures to assure the accurate acquiring, receiving, dispensing and administering of pharmaceuticals to meet residents' needs were implemented for 1 of 7 residents (R15) reviewed during medication	F 425	The Ordering and Re-Ordering of Medications Policy was revised as of 11/15/2017, to reflect changes of the re-ordering of medications. If the order is marked RTS, (Refill too soon), by Pharmacy, then action needs to be taken	11/22/17

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F 425	Continued From page 5 administration. Finding include: R15's Diagnosis Report dated 2/28/17, indicated R15 had diagnoses which included dementia with behavioral disturbance and constipation. R15's quarterly Minimum Data Set (MDS) dated 8/6/17, indicated R15 had severe cognitive impairment and required extensive assist of two staff for bed mobility, transfer and toilet use and extensive assist of one staff for locomotion on and off the unit, dressing and personal hygiene. R15's Physician Order Report dated 8/21/17 - 9/21/17, signed by the physician on 9/22/17, included an order for Doc-Q-Lace (stool softener) 100 milligrams (mg) twice a day, a.m. and HS [bedtime], for constipation. On 10/23/17, at 7:10 p.m. registered nurse (RN)-C was observed to administer R15's evening medications which included: donepezil 10 mg 1 tablet, levetiracetam 500 mg 1 tablet, Namenda XR 21 mg 1 capsule, propranolol 10 mg 1 capsule, and simvastatin 20 mg 1 tablet. The HS dose of Doc-Q-Lace was not observed to be given. R15's Medication Administration History (MAH) dated 10/1/17 to 10/26/17, included an order for Doc-Q-Lace 100 mg twice a day, a.m. and HS for	F 425	as follows: If the refill too soon is for less than one week, then Pharmacy should send the medication for the resident at Care Center Cost. The medication will be delivered by the Pharmacy so that is is available before the next dosage time. If the medication is ordered over a week early, then Pharmacy will contact Charge Nurse and together they will determine why the medication ran out or if they are about to run out. If there is a definite problem, the Director of Nursing and Pharmacy Director are to be notified. All licensed Nursing staff to be in-serviced on the Rights of Medication Pass and Proper Documentation of Medications by 11/22/2017. Director of Nursing, or Designee, to monitor monthly, and PRN, (as needed), for proper procedures. Correct pharmaceutical procedures and dispensing will be audited by the Director of Nursing or the Pharmacy Director to ensure proper delivery of medications. This will be reviewed at weekly Interdisciplinary Meetings under QAPI on Tuesdays, and reviewed again during quarterly Quality Assurance Meeting in January.	

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F 425	Continued From page 6 constipation. Medication reconciliation of the Doc-Q-Lace revealed the following: 10/19/17: HS dose not administered: drug/item not available 10/20/17: AM dose documented as given. HS dose not administered: drug/item not available 10/21/17: AM dose documented as given. HS dose not administered: drug/item not available 10/22/17: AM dose documented as given. HS dose not administered: drug/item not available 10/23/17: AM dose documented as given. HS dose not administered: drug/item not available 10/24/17: AM dose documented as given. HS dose documented as given 10/25/17: AM dose documented as given On 10/25/17, at 9:42 a.m. R15's MAH was reviewed with RN-D. RN-D confirmed the HS doses of Doc-Q-Lace from 10/19/17, through 10/23/17, were documented as not given, however, the a.m. doses for the same dates were documented as given. She also confirmed the a.m. and HS doses on 10/24/17, were documented as given, as well as the a.m. dose for 10/25/17. RN-D checked the medication cart and determined R15's medication drawer did not contain Doc-Q-Lace. RN-D confirmed that although she had documented the medication as given that morning, there was no medication available and the documentation was in error. RN-D stated she felt the a.m. doses 10/20/17, to 10/25/17, as well as the 10/24/17, HS doses were also documented in error. RN-D checked the medication reorder sheet and indicated a request	F 425		

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F 425	Continued From page 7	F 425		

was faxed to the pharmacy on 10/19/17, to refill the medication. The Pharmacy Order List was reviewed and identified a request for Doc-Q-Lace was requested on 10/19/17. An indication of "RTS 10/21/17" was written in the reason not filled section after the request. RN-D indicated RTS meant refill too soon.

On 10/25/17, at 1:38 p.m. the Pharmacy Director (PD), Pharmacist Tech (PT) and Consulting Pharmacist (CP)-A were interviewed. PT confirmed RTS was an indication of refill too soon and the date of 10/21/17, would be the date the medication was due to be refilled. PT confirmed the medication had been requested on 10/19/17, and indicated the medication was actually refilled on 10/23/17. An explanation of who was responsible to follow up on early refill requests and why the medication was not refilled on 10/21/17, was not provided. PT indicated the care center staff were notified to pick up the medication but had not done so. CP-A indicated the medication had still been in the pharmacy on the night of 10/24/17. PT indicated the medication had been delivered that morning (10/25/17). PD confirmed Doc-Q-Lace was not a medication provided in the emergency kit and R15 would not have had the medication available to be administered.

On 10/25/17, at 2:01 p.m. RN-D explained the process for requesting medication refills and stated the night shift reviewed the resident medications and faxed requests to the pharmacy for those residents who required a refill. RN-D confirmed the request for R15's medication was faxed to the pharmacy on the evening of

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F 425	Continued From page 8 10/19/17. RN-D confirmed the doses documented as given after 10/19/17, could not have been given, as the medication had not been available. She stated she accidentally documented she had given it today and confirmed she had not. RN-D stated the medication had been delivered today after the morning medication pass, at approximately 11:30 a.m. The bottle was reviewed and the medication dispensing date was noted to be 10/23/17. RN-D indicated she had called the pharmacy today to let them know they still needed the medication. On 10/25/17, at 2:20 p.m. the director of nursing (DON) confirmed it was her belief R15 had not received the medication even though it was documented he had. DON indicated she did not know why R15's medication ran out prior to the refill date and would be working with pharmacy staff to ensure medications were sent when needed, regardless of reimbursement status. The DON asked RN-D if the facility had any system for obtaining medication when refill was too early for reimbursement and RN-D stated they did not have a formal process. DON confirmed the resident should have received the medication. The Medication, Receiving from Pharmacy policy dated 11/2016, indicated the licensed nurse who called/faxed the medication order to the pharmacy was to inform the pharmacist of the exact physician order. The policy also indicated upon receipt of the medication the licensed nurse was to examine the physician order in the resident's medical record against the labeling instructions on the the container of the medication	F 425		

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F 425	Continued From page 9 received. The policy did not address responsibilities/processes for follow up of refills requested prior to refill dates nor did it identify appropriate actions to be taken when medications were not available to meet residents' needs. The Medication Management policy dated 11/2016, indicated when passing medications, the nurse had the responsibility of insuring the correct medication, correct dose, correct time, correct route, and correct person to who the medication was given. The policy directed licensed nurses and trained medication aids to chart medication, after the resident took the medication, in their individual MAR [medication administration record].	F 425		
F 441 SS=F	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures	F 441		11/17/17

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F 441	Continued From page 10 for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 441		

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F 441	Continued From page 11 (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were administered utilizing appropriate infection control techniques for 3 of 7 residents (R1, R10, R15, R11) whose medication pass was observed. In addition, the facility failed to ensure surveillance logs were completed, failed to complete investigations of infections and/or infectious trends, and failed to perform and document infection prevention measures based on infectious trends. This had the potential to effect all residents, visitors, and staff. Finding include: Medication administration On 10/23/17, at 7:02 p.m. registered nurse (RN)-C was observed at the medication cart in the facility common area. RN-C removed a bottle of Senna 8.6 milligrams (mg) from the medication cart, shook two tablets into her bare hand and placed them in a medication cup. RN-C proceeded to remove a bottle of acetaminophen 325 mg from the medication cart and shook two tablets into her bare hand and placed into the medication cup. RN-C crushed the medications, returned them to the medication cup, added a	F 441	Facility will utilize the Minnesota Department of Health Long Term Care Line List, in which the facility will incorporate a System of Surveillance that will identify possible communicable diseases or infections before they can spread to other persons within the Facility. Additionally, the Line List will identify the following: When and to whom incidents of Communicable Diseases should be reported, precautions necessary for facility to prevent spread of infections. The Policy will reflect the need for isolation and what type of isolation measures are needed. Facility to begin using this MDH List effective 11/22/2017. A separate Infection Prevention and Control Policy,(IPCP), for staff, to be completed by 11/22/2017, will identify when staff with a communicable disease or infected skin lesions, will be prohibited from any direct contact with residents and their food. Correct Hand Hygiene procedures, including Medication Passes, will be audited weekly for 4 weeks beginning November 22, and monthly for 4 months, and quarterly thereafter, for all staff who	

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F 441	Continued From page 12 spoonful of applesauce to the cup and administered the medication to R1. RN-C returned to the medication cart and applied hand sanitizer. --at 7:06 p.m. RN-C removed a container of levetiracetam 500 mg from the medication cart, poured one tablet into her bare hand and placed the tablet into a medication cup. RN-C administered the medication to R10. RN-C returned to the medication cart and applied hand sanitizer. --at 7:10 p.m. RN-C removed the following medications from the medication cart one at a time and dispensed them into her bare hand prior to placing in a medication cup: donepezil 10 mg 1 tablet, levetiracetam 500 mg 1 tablet, Namenda XR 21 mg 1 capsule, propranolol 10 mg 1 capsule, and simvastatin 20 mg 1 tablet. RN-C administered the medication to R15 and returned to the medicaiton cart and applied hand sanitizer. --at 7:23 p.m. RN-C removed the following medication from the medication cart, one at a time, and dispensed them into her hand prior to placing in a medication cup: donepezil 10 mg 1 tablet, gabapentin 100 mg 2 capsules, simvastatin 40 mg 1 tablet. RN-C administered the medication to R11 and returned to the medicaiton cart and applied hand sanitizer. --at 7:36 p.m. RN-C stated she did not recall having training specific to the practice of dispensing medication into her bare hand. On 10/26/2017, at 12:00 p.m. the director of nursing confirmed dispensing medication into the	F 441	have direct contact with resident population. This remain in effect as of 11/22/2017. This will be reviewed quarterly during Quality Assurance Meeting and during weekly Interdisciplinary Team meeting under QAPI. Director of Nursing implemented Infection Control Program to include surveillance tracking, (map), to identify infectious trends. This Program will investigate, control, and prevent infections, determine isolation. Director of Nursing will serve as the individual responsible for directing the infection control activities effective immediately, 10/26/2017. Director of Nursing implemented the addition to the Infection Control Program to include Surveillance tracking, (using a facility map with resident room numbers), to identify infectious trends. Medication pass policy to include not dispensing medication into bare hands by staff. Policy updated effective 11/22/2017. All Infection Control processes, through QAPI, (Quality Assurance Performance Improvement), will be reviewed and monitored Quarterly during Quality Assurance, as of next meeting in January, 2018. Policy for Linen Transportation, handling, and storage will be developed to prevent potential spread of infection, will be in place by 11/22/2017. In-service training	

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F 441	Continued From page 13 bare hand would be an infection control concern and was not a standard of practice for medication administration. The Medication Management policy dated 11/2016, indicated infection control was a major part of medication passing and directed staff to be sure hands were washed well according to guidelines, or use appropriate health care hand washing technique. The policy did not address dispensing of medications into bare hands. Infection control program On 10/26/17, at 10:28 a.m. RN-A was interviewed and confirmed she was responsible for infection control, however explained she was only responsible for getting the antibiotic stewardship program ready for implementation at the end of November, and was not aware she had been assigned to the oversight of the entire program. RN-A stated staff nurses tracked the infections on a surveillance log in real time, however, no one was evaluating, investigating the infections or infectious trends, and no one was in charge of putting measures in place for prevention and or containment. The infection surveillance logs included name of resident, date, room number, symptoms and time of onset, organism/culture, if the infection was present on admission, treatment, and outcome. The record lacked surveillance logs for July, August, and September. The logs lacked identification of infections that were facility acquired and did not consistently identify treatment, type and duration of antibiotic, and	F 441	was provided by Director of Nursing on November 16, 2017 and monitored under QAPI by IDT, (Inter-Disciplinary Team), meeting weekly. Nurses to be in-serviced on Proper procedure for Medication Pass, documentation and proper hand hygiene by 11/22/2017.	

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F 441	Continued From page 14 outcome. The record further lacked documentation of infection control activities to identify cause, measures to control or prevent the spread of infection even when the logs in January revealed eight residents with signs and symptoms of respiratory infections and February logs identified four residents with signs and symptoms of respiratory infections. RN-A confirmed the logs were lacking and verified there was no documentation of analysis of infections or infectious trends and did not include evidence of prevention or containment activities. At 12:00 p.m. the DON stated she was not aware RN-A was not overseeing the entire infection control surveillance program and confirmed the program was lacking. The DON stated surveillance tracking should have included a map in order to identify infectious trends and the logs were supposed to be analyzed so preventative and control measures could be put into place. Facility policy F441 483.65 Infection Control last reviewed 4/20/17, indicated the facility must establish an infection control program under which it investigated, controlled and prevented infections in facility, decided what procedures such as isolation should be applied to an individual resident and maintained a record of incidents and corrective actions related to infections. The policy also indicated a nursing home must assign one person, either a registered nurse or physician, the responsibility of directing infection control activities in the nursing home.	F 441		

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	245251	A. BUILDING _____ B. WING _____	10/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 15 Facility policy and procedure Infection/Illness Tracking last revised 12/16, indicated Illness and infections would be tracked for correlations and all symptoms would be tracked, and the infections, symptoms would be discussed weekly at interdisciplinary meetings as well as quarterly quality assurance meetings.	F 441		

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	245251	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**10/24/2017**

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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, Fire marshal Division . The time of this survey RiverView Nursing Home 01 Main Building was not found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99 Health Care Facilities Code.

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

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/17/2017

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	K 000		

Or by e-mail to:
Marian.Whitney@state.mn.us
and
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

RiverView Nursing Home is a 1-story building without a basement. The building was constructed at 2 different times. The original building was constructed in 1974 and was determined to be of a Type II(000) construction. In 2003 the south wing addition was built with additions to and remodeling of the north wing. It was determined to be of a Type V (111) construction.
In 2012 the facility reduced its licensed bed count to 24.

The nursing home is divided into 2 smoke compartments and is separated from the remainder of the building by two, 2 hour fire barriers.

The facility has a fire alarm system with smoke detection throughout the corridor system and in

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K 000	Continued From page 2 the common spaces. The fire alarm system is monitored for automatic fire department notification and is installed in accordance with NFPA 72 "The National Fire Alarm Code" . The sleeping rooms created in 2003 have single station smoke detectors installed, with an alarm at the nurse's station and on the corridor side of the rooms. The building has an automatic sprinkler system installed in accordance with NFPA 13 Standard for Installation of Automatic Sprinkler Systems. The facility has a capacity of 24 beds and had a census of 23 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide unobstructed access to the means of egress as required by the Life Safety Code (NFPA 101) 2012 edition section 19.2.1 & 7.1.6. This deficient practice could affect the exiting ability of 12 of the 24 residents and an undetermined amount of staff and visitors.	K 211	The sidewalk at exit 19 was professionally raised on 11-14-2017. It is no longer a tripping hazard.	11/14/17

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K 211	Continued From page 3 Findings include: At 11:35 am on 01/24/2017 observations revealed the sidewalk at exit 19 heaved up approximately 2 inches higher than the adjacent section. This deficient condition was confirmed by the Environmental Services Supervisor	K 211		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces	K 321		12/14/17

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K 321	Continued From page 4 (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain one hazardous room in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2. This deficient condition could allow smoke or fire to enter adjacent rooms and the corridor making it untenable and affect the quick and efficient exiting for an undetermined amount of staff and visitors. Findings include: At 11:16 am on 10/24/2017 observations revealed the door on soiled utility room 608 did not have a listing showing the one hour requirement as required when the wing was built. This deficient condition was confirmed by the Environmental Services Supervisor	K 321	The Director of Plant Services ordered a new, 1 hour fire resistant rated door for this soiled utility room on 11-06-2017. There is a 3 - 4 week lead time on this door arriving from the manufacturer. The new door, with proper rating, will be installed upon arrival, by December 14, 2017.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K 345		11/15/17

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K 345	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain the smoke detection system as required by the Life Safety Code,(LSC) 2012 edition, section 9.6.1.5 & 8.5.5.7.1 and NFPA 72, The National Fire Alarm and Signaling Code, 2010 edition, section 14.3.1. This deficient condition could delay alarm notification in case of a fire and affect all 24 residents and an undetermined amount of staff and visitors. Findings include: At 10:25 am on 10/24/17 documentation review revealed the fire alarm report listed 2 less duct detectors tested than the 2016 report. This deficient condition was confirmed by the Environmental Services Supervisor	K 345	During our Operating Room HVAC Project, two duct detectors were removed when the old equipment was eliminated. These detectors were no longer needed in this area and the report reflecting the correct total number of smoke detectors in the building, was updated on 11-15-2017.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____	K 353		11/15/17

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K 353	Continued From page 6 c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect all of the 24 residents and an undetermined amount of staff and visitors. Findings include: At 10:25 am on 10/24/17 record review revealed there was no documentation of the last 5 year internal pipe inspection or the last 5 year gauge calibration/replacement. This deficient condition was confirmed by the Environmental Services Supervisor	K 353	Records of Sprinkler maintenance and testing, performed by Dakota Fire, shall include date, name of inspection company, and water system supply source. The records will be kept by the Environmental Services Supervisor. The 5 year term on gauge replacement on standpipe will be replaced by January 31, 2018, by Dakota Fire, which is when the 5 year term is due. Non-removable tags will be placed on the gauges to indicate date they were replaced. Environmental Services Supervisor confirmed the type of standpipe in facility is a Manual Wet Standpipe, under NFPA 6.3.2.1.1., which is a combined sprinkler/standpipe. Dakota Fire is the current provider for the Sprinkler system inspection and maintenance for the facility.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct	K 372		10/24/17

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K 372	Continued From page 7 penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain one smoke barrier as required by the 2012 Life Safety Code (NFPA 101) section 19.3.7.3, 8.8.7.1 (1). This deficient practice could allow smoke to transfer from one smoke compartment to another affecting the exiting of 12 of the 24 residents and an undetermined amount of staff and visitors. Findings include: At 11:15 am on 10/24/2017 observations revealed a penetration in the center smoke barrier by a 3 inch pipe above the cross corridor doors that did not have the proper fire stopping. This deficient condition was confirmed by the Environmental Services Supervisor.	K 372	The center smoke barrier with a 3 inch pipe penetration above the cross-corridor doors, was fire-caulked with approved sealant fire-proofing. This was completed on 10/24/2017.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and	K 712		11/3/17

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K 712	Continued From page 8 conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to record fire drill participants on each shift as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.6 . This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all 24 residents and an undetermined amount of staff and visitors. Findings include: At 9:30 am on 10/24/17 documentation review revealed the fire drill reports did not contain the signatures of the employees participating in the drills. This deficient condition was confirmed by the Environmental Services Supervisor.	K 712	A Staff Participation Section has been added to our Fire Drills, to include the signatures of employees who participate in the drills. This was completed with an effective date of 11/03/2017.	