



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5572

December 19, 2013

Ms. Patrice Goette, Administrator
Colonial Manor Nursing Home
403 Colonial Avenue
Lakefield, Minnesota 56150

Dear Ms. Goette:

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 August 12, 2013, the above facility is certified for:

37 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 37 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,

A handwritten signature in cursive script that reads "Colleen Leach".

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

Colonial Manor Nursing Home

December 19, 2013

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Protecting, Maintaining and Improving the Health of Minnesotans

August 20, 2013

Ms. Patrice Goette, Administrator
Colonial Manor Nursing Home
403 Colonial Avenue
Lakefield, Minnesota 56150

RE: Project Number S5572022

Dear Ms. Goette:

On July 16, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 27, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 12, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on August 2, 2013 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 June 27, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 12, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 27, 2013, effective August 12, 2013 and therefore remedies outlined in our letter to you dated July 16, 2013, 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.

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Shellae Dietrich". The signature is written in a cursive, slightly slanted style.

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

5572r113.rtf

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 245572	(Y2) Multiple Construction A. Building _____ B. Wing _____	(Y3) Date of Revisit 8/12/2013
Name of Facility COLONIAL MANOR NURSING HOME		Street Address, City, State, Zip Code 403 COLONIAL AVENUE LAKEFIELD, MN 56150

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 F0329 Reg. # 483.25(I) LSC _____	Correction Completed 08/12/2013	ID Prefix F0428 Reg. # 483.60(c) LSC _____	Correction Completed 08/12/2013	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____	Reviewed By KS/sd	Date: 08/20/13	Signature of Surveyor: 28588	Date: 08/12/13
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 6/27/2013	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> </table>	YES	NO
YES	NO		

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 245572	(Y2) Multiple Construction A. Building 01 - MAIN BUILDING 01 B. Wing	(Y3) Date of Revisit 8/2/2013
Name of Facility COLONIAL MANOR NURSING HOME	Street Address, City, State, Zip Code 403 COLONIAL AVENUE LAKEFIELD, MN 56150	

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # NFPA 101 LSC K0052	Correction Completed 07/08/2013	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____	Reviewed By PS/sd	Date: 08/20/13	Signature of Surveyor: 25822	Date: 08/02/13
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 6/27/2013	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> </table>	YES	NO
YES	NO		



Protecting, Maintaining and Improving the Health of Minnesotans

August 20, 2013

Ms. Patrice Goette, Administrator
Colonial Manor Nursing Home
403 Colonial Avenue
Lakefield, Minnesota 56150

Re: Enclosed Reinspection Results - Project Number S5572022

Dear Ms. Goette:

On August 12, 2013 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 27, 2013 with orders received by you on July 22, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads "Shellae Dietrich".

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5572r113lic.rtf

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number 00302	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 8/12/2013
Name of Facility COLONIAL MANOR NURSING HOME	Street Address, City, State, Zip Code 403 COLONIAL AVENUE LAKEFIELD, MN 56150	

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>21530</u>	Correction Completed 08/12/2013	ID Prefix <u>21535</u>	Correction Completed 08/12/2013	ID Prefix <u>21540</u>	Correction Completed 08/12/2013
Reg. # <u>MN Rule 4658.1310 A.B.C</u>		Reg. # <u>MN Rule 4658.1315 Subp.1 ABC</u>		Reg. # <u>MN Rule 4658.1315 Subp. 2</u>	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	

Reviewed By _____	Reviewed By <u>KS/sd</u>	Date: <u>08/20/13</u>	Signature of Surveyor: <u>28588</u>	Date: <u>08/12/13</u>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: <u>6/27/2013</u>	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> </table>	YES	NO
YES	NO		

C&T REMARKS - CMS 1539 FORMSTATE AGENCY REMARKS

CCN# 24-5572

At the time of the standard survey completed June 27, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 3168

July 16, 2013

Ms. Patrice Goette, Administrator
Colonial Manor Nursing Home
403 Colonial Avenue
Lakefield, Minnesota 56150

RE: Project Number S5572022

Dear Ms. Goette:

On June 27, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793

Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 6, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 6, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 27, 2013 (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 December 27, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

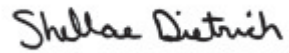
Colonial Manor Nursing Home

July 16, 2013

Page 6

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads "Shellae Dietrich".

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

5572s13.rtf

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

PRINTED: 07/16/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245572	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2013
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NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 403 COLONIAL AVENUE LAKEFIELD, MN 56150
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

F 000

THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

F 329 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS
SS=E

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

F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

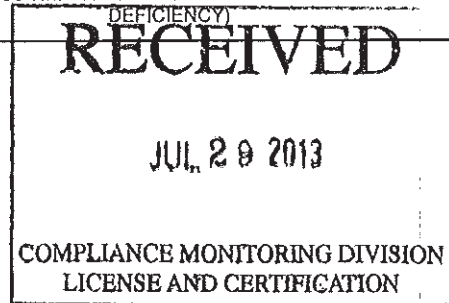
Corrective Action: To assure that the facility will properly monitor for target behaviors and document effectiveness of non-pharmacological interventions for residents on anti-psychotic and anti-anxiety medications. This will be corrected for residents R11, R10, R37, R46 and R9 with the implementation of a new psychotropic monitoring form (Behavior/Intervention Monthly Flow Record) that will be implemented and completed by the licensed nurse on every shift for as long as the resident is on these medications and will be completed by 07/29/2013. Target behaviors will also be monitored for 30 days post discontinuation of anti-psychotic/anti-anxiety medications.

To prevent future occurrences of this deficiency all new admissions and current residents on anti-psychotics and/or anti-anxiety medications will have this monitoring system implemented and will continue as long as resident has these medications ordered by a physician. These monitoring tools will be reviewed by a psychiatrist and facility pharmacy consultant on a monthly basis.

Licensed nurses, TMA's, and CNA's were provided education on the new monitoring form and process on 07/17/2013. Social Service Director also reviewed new monitoring form. Psychotropic Drug Monitoring Policy and Procedure reviewed and revised on July 24, 2013 in accordance with the changes made and will be reviewed by social services and nursing staff by July 29, 2013.

This corrective action will be reviewed at the monthly internal QA and Quarterly QA meetings.

Corrective Action Completed by ~~08/15/2013~~ 8/6/13



7/30/13
SER

8/6/13 ✓

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Patrice Gaulte, CNHA</i>	TITLE <i>Administrator</i>	(X6) DATE <i>7-25-13 ✓</i>
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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.

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

PRINTED: 07/16/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245572	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2013
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NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 403 COLONIAL AVENUE LAKEFIELD, MN 56150
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 329	<p>Continued From page 1 drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not provide indications for continued use, mood monitoring, monitoring for effectiveness of non-pharmacological interventions, monitoring for target behaviors of psychoactive medications and monitoring for medication side effects, for 5 of 10 residents (R11, R10, R37, R46 and R9) reviewed for unnecessary medication use.</p> <p>Findings include: The facility did not routinely monitor target behaviors and did not routinely document effectiveness of non-pharmacological interventions for R11.</p> <p>Review of R11's current physician orders signed 6/13/13, included Seroquel (an antipsychotic medication), 25 milligrams (mg) daily and 50mg daily at bedtime for agitation/hallucinations and lorazepam (an anti-anxiety medication), 0.5mg three times daily. Review of R11's record, 6/25/13, revealed R11 had diagnoses that included Lewy Body dementia, depression, anxiety and hallucinations.</p> <p>Review of The Informed Consent: Psychotropic Medication form dated 1/11/13, listed Seroquel and lorazepam as medications used for R11.</p>	F 329		
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F 329 Continued From page 2

The form detailed agitation, self-transfers, and anger as the target behaviors related to R11's need for these medications. No ongoing, consistent monitoring of these target behaviors was located in R11's record.

R11's current care plan dated 4/24/13, noted, "Anxiety/Behavioral symptoms-Resident wanting to walk and stand without assistance/wandering in facility/uncertainty of what to do." Several non-pharmacological interventions were listed, such as taking R11 for a walk or offering green tea and finger food snacks. Several Behavior Incident Checklist forms were included in R11's record. These forms were completed only when an "as needed" medication was administered to a resident. The Behavior Incident Checklist forms were the sole form of documentation for the effectiveness of non-pharmacological interventions for R11.

When interviewed on 6/27/13, at 8:30 a.m. the director of nursing (DON) confirmed that the facility did not have routine target behavior monitoring documented for residents who were prescribed psychoactive medications. She stated that target behaviors were monitored by nursing staff for 30 days when psychoactive medications were started or stopped. She added that nursing assistants recorded behavior occurrences in their documentation, but did not specifically address target behaviors related to the psychoactive medications that were prescribed. At 11:30 a.m., the DON verified the Behavior Incident Checklist forms were only used when an as needed medication was administered to a resident.

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F 329	Continued From page 3 Review of R10's current physician orders signed 6/20/13, included Zyprexa (antipsychotic medication) 2.5 mg every evening, Ativan (antianxiety medication) 0.5 mg twice daily and Namenda (dementia/ Alzheimer's medication) 5mg twice daily. The quarterly Minimum Data Set (MDS) dated 6/13/13, revealed R10 had moderately impaired cognition and identified no behavior issues or mood symptoms were present. Review of the record, 6/26/13, revealed R10 diagnoses included dementia with behavioral disturbances, anxiety, depression and insomnia. Review of R10's Behavior-Medication Monitoring form completed by the facility's consultant pharmacist (CP) on 4/22/13, indicated that in 3/13 Zyprexa was discontinued, but then restarted due to obsessive compulsive-type health complaints that surfaced. The CP noted a "high degree of anxiety" for R10 and recommended discontinuation of Namenda, given no indication for use was located in the record and it potentially contributed to R10's anxiety. The CP added that if R10's Zyprexa was keeping her anxiety under control, then a reduction in her Ativan, from scheduled to an "as needed" basis was recommended. The physician response to these recommendations noted, "No change now." The nursing staff report for these recommendations noted, "Resident's husband passed away recently. Multiple trials of changes to psych meds have been unsuccessful." Review of R10's medical record lacked identified target behaviors for the use of her psychoactive medications. The record also lacked evidence of target behavior monitoring, mood monitoring and monitoring for effectiveness of non-pharmacological interventions. In addition,	F 329			

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F 329	<p>Continued From page 4</p> <p>the record lacked indication for R10's use of Namenda.</p> <p>During interview on 6/27/13, at 9:30 a.m. DON stated R10 was on Zyprexa due to obsessive compulsive behavior, such as repeatedly stating, "bathroom, bathroom, bathroom." DON indicated her Zyprexa was discontinued in 2/13 and was restarted in 3/13, with R10 having remained stable since this restart. DON revealed R10 had been on Ativan since 2009, with a reduction from 0.5 mg three times daily to 0.5 mg twice daily on 12/13/12. Upon inquiry, DON stated the nursing staff were expected to document target behaviors, mood/behavior monitoring and non-pharmacological interventions in the nursing progress notes; however, no such documentation could be located in the record.</p> <p>Review of R37's current physician orders dated 5/20/13, included Ativan 0.5 mg three times daily and Celexa 20mg daily at bedtime, with the Celexa having been initiated on 4/26/13. The quarterly MDS dated 5/3/13, identified R37 was cognitively intact and had exhibited no behaviors. Review of the record, 6/26/13, revealed R37's diagnoses included anxiety, depression, bipolar disorder, malaise and fatigue.</p> <p>Review of R37's record lacked identification of specific anxiety symptoms to indicate the use of Ativan. The record also lacked monitoring of R37's mood, medication side effects and effectiveness of non-pharmacological interventions.</p> <p>During interview on 6/27/13, at 9:30 a.m. DON stated R37 had received Ativan for anxiety since prior to her readmission to the facility. DON revealed continued use of Ativan was discussed with R37's family member, who did not want it to</p>	F 329		

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F 329	<p>Continued From page 5</p> <p>be discontinued. Upon inquiry as to the specific anxiety symptoms R37 had been exhibiting, DON verified R37's record lacked identification of specific anxiety related symptoms. DON confirmed pertinent documentation was lacking in R37's record, related to mood monitoring, monitoring of medication side effects and non-pharmacological intervention attempts. Review of R46's current physician orders included Seroquel 12.5 mg every evening. The admission MDS dated 6/3/13, identified R46 was moderately cognitively impaired and exhibited behaviors of inattention and disorganized thinking. Review of the record, 6/26/13 identified R46's diagnoses included senile dementia with delusions, Alzheimer's disease, depressive disorder and aphasia.</p> <p>Review of R46's Behavior-Medication Monitoring form completed by the CP on 6/19/13, noted, "Nurses report injurious behaviors of hitting, biting, grabbing neck during cares. Non med interventions not reported." CP added, "Seroquel 12.5 mg is ordered. There is history of dementia with depressive features ...No psychosis or injurious behaviors are described. If psychosis is a problem the specific symptoms must be documented for monitoring. Nurse's report [R46] hits out during cares and is injurious. This must be documented ... [R46] has tried to bite nurses, throw items off carts at nurses. Non-medication interventions have not been tried because she is a recent admit [admission]." CP recommended the facility document R46's baseline behaviors, report dose responses and document attempt to control her behaviors through non-pharmacological interventions. The nursing staff documented on this form, "Good behavior</p>	F 329		

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F 329 Continued From page 6

charting is in place and current." Review of R46's medical record revealed a lack of indication for the use of Seroquel, target behavior monitoring, side effect monitoring and monitoring for effectiveness of non-pharmacological interventions. During interview on 6/27/13, at 9:30 a.m. DON stated R46 had been receiving Seroquel since prior to her admission to the facility. DON was unable to locate documentation as to why R46 was taking Seroquel and stated that sometimes family members wanted residents to take antipsychotic medications and resisted having them discontinued. DON stated pertinent documentation was lacking for R46 relating to target behavior monitoring, medication side effect monitoring and non-pharmacological intervention attempts. DON confirmed the facility's psychotropic medication monitoring system needed to be improved to ensure each medication had clear indications for use and a method for appropriate monitoring for effectiveness and adverse side effects.

Review of R9's current physician orders signed 5/9/13, included Risperdal 0.25 mg (an antipsychotic medication) for dementia with psychosis, which was discontinued on 2/26/13 and restarted on 4/16/13. Review of the record revealed R9's diagnoses included senile dementia with depressive features, unspecified psychosis and major depressive disorder.

Review of physician progress notes dated 4/16/13 revealed, R9 had been prescribed Risperdal in the past, but it was discontinued secondary to

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F 329	<p>Continued From page 7</p> <p>CP's recommendation. The note added, "Now pt [patient] agitated and irritable at times ... severe word finding problems ... paranoia... will restart pt on Risperdal. Pt failed GDR [gradual dose reduction]. Risperdal 0.25 mg po qd [orally daily]."</p> <p>Review of R9's record revealed Psychotropic Monitoring Following a Start, Change or Stop in Medication forms dated 4/13 and 5/13. The forms identified the medication that was given and the "area being monitored." Both forms listed behaviors, agitation and anger as being monitored for R9. No specific target behaviors were listed on the forms. No non-pharmacological interventions were listed or monitored for effectiveness. The forms revealed five episodes of agitation or anger which occurred between 4/17/13 and 5/19/13.</p> <p>Review of INFORMED CONSENT: Psychotropic Medication signed 4/16/13, revealed target behaviors for R9's use of Risperdal included yelling and running into things with his wheelchair. Non-pharmacological interventions listed included one-to-one time with staff, distraction, allowing him to express his feelings and giving him time/space as needed. The target behaviors listed on this consent form, where not listed on the Psychotropic Monitoring Following a Start, Change or Stop in Medication forms.</p> <p>Review of R9's record revealed a lack of routine monitoring for specified target behaviors and monitoring for the effectiveness of non-pharmacological interventions attempted.</p> <p>The facility's Psychotropic Drug Monitoring policy</p>	F 329		

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F 329	Continued From page 8 dated 9/05, read, "Consistent monitoring will be done to assess the risk/benefit relationship of psychotropic drug therapy, including the appropriateness of drug selection and dosage. F 428 483.60(c) DRUG REGIMEN REVIEW, REPORT SS=E IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the consulting pharmacist failed to advise the facility regarding lack of behavior monitoring and failed to make recommendations to the facility regarding irregularities identified, related to indications for continued use, mood monitoring, monitoring for effectiveness of non-pharmacological interventions, monitoring for target behaviors of psychoactive medications and monitoring for medication side effects, for 5 of 10 residents (R11, R10, R37, R46 and R9) reviewed for unnecessary medication use. Findings include: Record review, on 6/25/13, revealed R11's	F 329	F428 DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON Corrective Action: To ensure that pharmacy consultant reviews monthly for correct behavior monitoring and makes recommendations regarding irregularities. A new form (Behavior/Intervention Monthly Flow Record) that a licensed nurse will be completing every shift, will be implemented for the pharmacy consultant to review and sign monthly. This will be located in a binder at the nurse's station. This will be corrected for residents R11, R10, R37, R46 and R9 with the implementation of the new psychotropic monitoring form that will be completed by 07/29/2013. Target behaviors will also be monitored for 30 days post discontinuation of anti-psychotic/anti-anxiety medications. To prevent future occurrences of this deficiency all new admissions and current residents on anti-psychotics and/or anti-anxiety medications will have this monitoring system implemented and will continue as long as resident has these medications ordered by a physician. This corrective action will be reviewed at the monthly internal QA and quarterly QA meetings. The consulting pharmacist was notified on 7/23/2013 of the corrective action for this deficiency. The Revised Psychotropic Drug Monitoring Policy and Procedure will be reviewed by the Consulting Pharmacist on his regularly scheduled monthly visit. Corrective Action Completed by 8/15/2013. 8/6/13	

8/6/13 ✓

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F 428 Continued From page 9 F 428

diagnoses included Lewy Body dementia, depression, anxiety and hallucinations.

Review of R11's current physician orders signed 6/13/13, included Seroquel (an antipsychotic medication), 25 milligrams (mg) daily and 50mg daily at bedtime for agitation/hallucinations and lorazepam (an anti-anxiety medication), 0.5mg three times daily.

The Informed Consent: Psychotropic Medication form dated 1/11/13, listed Seroquel and lorazepam as medications used for R11. The form detailed agitation, self-transfers, and anger as the target behaviors related to R11's need for these medications. No ongoing, consistent monitoring of these target behaviors was located in R11's record.

R11's current care plan dated 4/24/13, noted, "Anxiety/Behavioral symptoms-Resident wanting to walk and stand without assistance/wandering in facility/uncertainty of what to do." Several non-pharmacological interventions were listed, such as taking R11 for a walk or offering green tea and finger food snacks. Several Behavior Incident Checklist forms were included in R11's record. These forms were completed only when an as needed medication was administered to a resident. The Behavior Incident Checklist forms were the sole form of documentation for the effectiveness of non-pharmacological interventions for R11.

Review of Behavior-Medication Monitoring form completed by the facility's consultant pharmacist (CP) dated 4/22/13, noted, "Agitation is not an accepted indication for using either Seroquel or

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F 428	<p>Continued From page 10</p> <p>lorazepam. Injurious or psychotic behavior must be documented for Seroquel. Notes report [R11] attempts to take off immobilizer and stand up out of wheelchair. Administration of Seroquel for these actions has not helped and may contribute to confusion. If she is delirious then her abnormal thoughts and actions should be documented. She has a history of hitting nurses, grabbing staff by the neck and locking herself in her room."</p> <p>When interviewed on 6/27/13, at 8:30 a.m. the director of nursing (DON) confirmed that the facility did not have routine target behavior monitoring documented for residents who were prescribed psychoactive medications. She stated that target behaviors were monitored by nursing staff for 30 days when psychoactive medications were started or stopped. She added that nursing assistants recorded behavior occurrences in their documentation, but did not specifically address target behaviors related to the psychoactive medications that were prescribed. At 11:30 a.m., the DON stated the Behavior Incident Checklist forms were only used when an as needed medication was administered to a resident.</p> <p>On 6/27/13, at 10:40 a.m., the CP was interviewed and stated that he looks for target behaviors and uses them during his review, if they are available. When asked about any documentation of effectiveness of non-pharmacological interventions, CP stated that he had no record of that, related to R11.</p> <p>R10 record review, 6/26/13, revealed R10's diagnoses that included dementia with behavioral disturbances, anxiety, depression and insomnia.</p>	F 428		

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F 428	<p>Continued From page 11</p> <p>Review of R10's current physician orders signed 6/20/13, included Zyprexa (antipsychotic medication) 2.5 mg every evening, Ativan (antianxiety medication) 0.5 mg twice daily and Namenda (dementia/ Alzheimer's medication) 5mg twice daily. The quarterly Minimum Data Set (MDS) dated 6/13/13, revealed R10 had moderately impaired cognition and identified no behavior issues or mood symptoms were present.</p> <p>Review of R10's Behavior-Medication Monitoring form completed by the facility's consultant pharmacist (CP) on 4/22/13, indicated that in 3/13 Zyprexa was discontinued, but then restarted due to obsessive compulsive-type health complaints that surfaced. The CP noted a "high degree of anxiety" for R10 and recommended discontinuation of Namenda, given no indication for use was located in the record and it potentially contributed to R10's anxiety. The CP added that if R10's Zyprexa was keeping her anxiety under control, then a reduction in her Ativan, from scheduled to an as needed basis was recommended. The physician response to these recommendations noted, "No change now." The nursing staff report for these recommendations noted, "Resident's husband passed away recently. Multiple trials of changes to psych meds have been unsuccessful."</p> <p>Review of R10's medical record lacked identified target behaviors for the use of her psychoactive medications. The record also lacked evidence of target behavior monitoring, mood monitoring and monitoring for effectiveness of non-pharmacological interventions. In addition, the record lacked indication for R10's use of Namenda.</p> <p>During interview on 6/27/13, at 9:30 a.m. DON</p>	F 428		
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F 428	Continued From page 12 stated R10 was on Zyprexa due to obsessive compulsive behavior, such as repeatedly stating, "bathroom, bathroom, bathroom." DON indicated her Zyprexa was discontinued in 2/13 and was restarted in 3/13, with R10 having remained stable since this restart. DON revealed R10 had been on Ativan since 2009, with a reduction from 0.5 mg three times daily to 0.5 mg twice daily on 12/13/12. Upon inquiry, DON stated the nursing staff were expected to document target behaviors, mood/behavior monitoring and non-pharmacological interventions in the nursing progress notes; however, no such documentation could be located in the record. R37, record review, 6/26/13, revealed R37's diagnoses included anxiety, depression, bipolar disorder, malaise and fatigue. Review of R37's current physician orders dated 5/20/13, included Ativan 0.5 mg three times daily and Celexa 20mg daily at bedtime, with the Celexa having been initiated on 4/26/13. The quarterly MDS dated 5/3/13, identified R37 was cognitively intact and had exhibited no behaviors. Review of R37's record lacked identification of specific anxiety symptoms to indicate the use of Ativan. The record also lacked monitoring of R37's mood, medication side effects and effectiveness of non-pharmacological interventions. During interview on 6/27/13, at 9:30 a.m. DON stated R37 had received Ativan for anxiety since prior to her readmission to the facility. DON revealed continued use of Ativan was discussed with R37's family member, who did not want it to be discontinued. Upon inquiry as to the specific anxiety symptoms R37 had been exhibiting, DON verified R37's record lacked identification of specific anxiety related symptoms. DON	F 428		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	<p>Continued From page 13</p> <p>confirmed pertinent documentation was lacking in R37's record, related to mood monitoring, monitoring of medication side effects and non-pharmacological intervention attempts. R46 record review 6/26/13, revealed diagnoses that included senile dementia with delusions, Alzheimer's disease, depressive disorder and aphasia.</p> <p>Review of R46's current physician orders included Seroquel 12.5 mg every evening. The admission MDS dated 6/3/13, identified R46 was moderately cognitively impaired and exhibited behaviors of inattention and disorganized thinking.</p> <p>Review of R46's Behavior-Medication Monitoring form completed by the CP on 6/19/13, noted, "Nurses report injurious behaviors of hitting, biting, grabbing neck during cares. Non med interventions not reported." CP added, "Seroquel 12.5 mg is ordered. There is history of dementia with depressive features ...No psychosis or injurious behaviors are described. If psychosis is a problem the specific symptoms must be documented for monitoring. Nurse's report [R46] hits out during cares and is injurious. This must be documented ... [R46] has tried to bite nurses, throw items off carts at nurses. Non-medication interventions have not been tried because she is a recent admit [admission]." CP recommended the facility document R46's baseline behaviors, report dose responses and document attempt to control her behaviors through non-pharmacological interventions. The nursing staff documented on this form, "Good behavior charting is in place and current."</p> <p>Review of R46's medical record revealed a lack of indication for the use of Seroquel, target behavior monitoring, side effect monitoring and</p>	F 428		

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

PRINTED: 07/16/2013
FORM APPROVED
OMB NO. 0938-0391

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F 428	<p>Continued From page 14</p> <p>monitoring for effectiveness of non-pharmacological interventions. During interview on 6/27/13, at 9:30 a.m. DON stated R46 had been receiving Seroquel since prior to her admission to the facility. DON was unable to locate documentation as to why R46 was taking Seroquel and stated that sometimes family members wanted residents to take antipsychotic medications and resisted having them discontinued. DON stated pertinent documentation was lacking for R46 relating to target behavior monitoring, medication side effect monitoring and non-pharmacological intervention attempts. DON confirmed the facility's psychotropic medication monitoring system needed to be improved to ensure each medication had clear indications for use and a method for appropriate monitoring for effectiveness and adverse side effects. R9 record review, 6/26/13, indicated diagnoses that included senile dementia with depressive features, unspecified psychosis and major depressive disorder.</p> <p>Review of R9's current physician orders signed 5/9/13, included Risperdal 0.25 mg (an antipsychotic medication) for dementia with psychosis, which was discontinued on 2/26/13 and restarted on 4/16/13.</p> <p>Review of physician progress notes dated 4/16/13 revealed, R9 had been prescribed Risperdal in the past, but it was discontinued secondary to CP's recommendation. The note added, "Now pt [patient] agitated and irritable at times ... severe word finding problems ... paranoia... will restart pt on Risperdal. Pt failed GDR [gradual dose reduction]. Risperdal 0.25 mg po qd [orally daily]."</p>	F 428		

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NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 403 COLONIAL AVENUE LAKEFIELD, MN 56150
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F 428 Continued From page 15

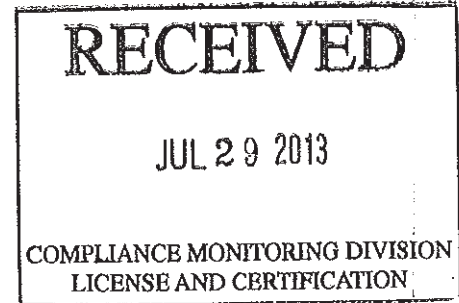
F 428

Review of R9's record revealed Psychotropic Monitoring Following a Start, Change or Stop in Medication forms dated 4/13 and 5/13. The forms identified the medication that was given and the "area being monitored." Both forms listed behaviors, agitation and anger as being monitored for R9. No specific target behaviors were listed on the forms. No non-pharmacological interventions were listed or monitored for effectiveness. The forms revealed five episodes of agitation or anger which occurred between 4/17/13 and 5/19/13.

Review of INFORMED CONSENT: Psychotropic Medication signed 4/16/13, revealed target behaviors for R9's use of Risperdal included yelling and running into things with his wheelchair. Non-pharmacological interventions listed included one-to-one time with staff, distraction, allowing him to express his feelings and giving him time/space as needed. The target behaviors listed on this consent form, where not listed on the Psychotropic Monitoring Following a Start, Change or Stop in Medication forms.

Review of R9's record revealed a lack of routine monitoring for specified target behaviors and monitoring for the effectiveness of non-pharmacological interventions attempted.

The facility's Psychotropic Drug Monitoring policy dated 9/05, read, "Consistent monitoring will be done to assess the risk/benefit relationship of psychotropic drug therapy, including the appropriateness of drug selection and dosage.



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

F5572022

PRINTED: 07/16/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245572	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2013
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NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 403 COLONIAL AVENUE LAKEFIELD, MN 56150
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K 000 INITIAL COMMENTS

K 000

FIRE SAFETY

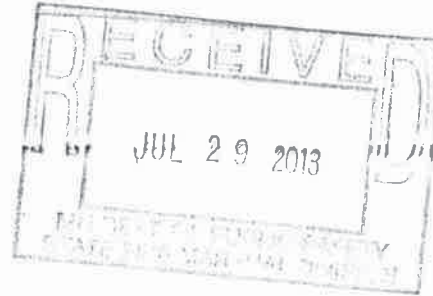
THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

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. At the time of this survey, Colonial Manor Nursing Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care 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 St., Suite 145
St Paul, MN 55101-5145, or



POC ok
FS 7-29-13

DC: 08.06.2013

EXIT: 06.27.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Patrice Hoette, CNHA</i>	TITLE <i>Administrator</i>	(X6) DATE <i>7-25-13</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 000	Continued From page 1 By email to: Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Colonial Manor Nursing Home original building was built in 1969, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction. An addition was built in 1979, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction. An addition was built in 1999, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 37 beds and had a census of 31 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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K 000 Continued From page 2
NOT MET as evidenced by:

K 052 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F
A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4

K 000
K 052 K 052
A second telephone line for the fire alarm dialer was installed and on July 8, 2013 Gopher Fire Alarm connected and tested the transmission of the second line.

The Maintenance Director will continue to test and maintain the fire alarm system as required to meet the Life Safety Code.

The Administrator will check quarterly that this is being completed.

Date of completion: 07/08/2013

This STANDARD is not met as evidenced by:
Based on observation and staff interview, the facility failed to test the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72- 5-5.3.2.1.6.1 and Table 7-2.2 (16) (b). This could effect all 31 residents.

Findings include:

On facility tour between 10:45 AM and 1:45 PM on 06/27/2013, observation revealed the following items were found:

1. The facility does not have two phone lines for the fire alarm dialer and
2. Testing of the only transmission line by unplugging the phone line revealed, that there was no trouble signal with-in 4 minutes to the

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K 052 Continued From page 3
premises fire alarm system and the monitoring company

K 052

These deficient practices were confirmed by the Facility Maintenance Director at the time of discovery.

TEAM COMPOSITION
Gary Schroeder, Life Safety Code Spc.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 3168

July 16, 2013

Ms. Patrice Goette, Administrator
Colonial Manor Nursing Home
403 Colonial Avenue
Lakefield, Minnesota 56150

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5572022

Dear Ms. Goette:

The above facility was surveyed on June 24, 2013 through June 27, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

Colonial Manor Nursing Home

July 16, 2013

Page 2

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

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

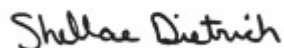
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, P.O. Box 64900, St. Paul, Minnesota 55164-0900. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5572s13lic.rtf

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00302	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2013
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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On June 24, 2013 through June 27, 2013, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of</p>	2 000	<p>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.</p>	

Minnesota Department of Health

TITLE

(X6) DATE

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00302	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/27/2013
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2 000	Continued From page 1 Compliance Monitoring, Licensing and Certification Programs; P.O. Box 64900, St. Paul, Minnesota 55164-0900.	2 000	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 which 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.		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is	21530			

Minnesota Department of Health

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21530	<p>Continued From page 2</p> <p>available through the Minitex interlibrary loan system. It is not subject to frequent change.</p> <p>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.</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the consulting pharmacist failed to advise the facility regarding lack of behavior monitoring and failed to make recommendations to the facility regarding irregularities identified, related to indications for continued use, mood monitoring, monitoring for effectiveness of non-pharmacological interventions, monitoring for</p>	21530		

Minnesota Department of Health

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21530	<p>Continued From page 3</p> <p>target behaviors of psychoactive medications and monitoring for medication side effects, for 5 of 10 residents (R11, R10, R37, R46 and R9) reviewed for unnecessary medication use.</p> <p>Findings include:</p> <p>Record review, on 6/25/13, revealed R11's diagnoses included Lewy Body dementia, depression, anxiety and hallucinations.</p> <p>Review of R11's current physician orders signed 6/13/13, included Seroquel (an antipsychotic medication), 25 milligrams (mg) daily and 50mg daily at bedtime for agitation/hallucinations and lorazepam (an anti-anxiety medication), 0.5mg three times daily.</p> <p>The Informed Consent: Psychotropic Medication form dated 1/11/13, listed Seroquel and lorazepam as medications used for R11. The form detailed agitation, self-transfers, and anger as the target behaviors related to R11's need for these medications. No ongoing, consistent monitoring of these target behaviors was located in R11's record.</p> <p>R11's current care plan dated 4/24/13, noted, "Anxiety/Behavioral symptoms-Resident wanting to walk and stand without assistance/wandering in facility/uncertainty of what to do." Several non-pharmacological interventions were listed, such as taking R11 for a walk or offering green tea and finger food snacks. Several Behavior Incident Checklist forms were included in R11's record. These forms were completed only when an as needed medication was administered to a resident. The Behavior Incident Checklist forms were the sole form of documentation for the</p>	21530			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER COLONIAL MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 403 COLONIAL AVENUE LAKEFIELD, MN 56150		
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21530	<p>Continued From page 4</p> <p>effectiveness of non-pharmacological interventions for R11.</p> <p>Review of Behavior-Medication Monitoring form completed by the facility's consultant pharmacist (CP) dated 4/22/13, noted, "Agitation is not an accepted indication for using either Seroquel or lorazepam. Injurious or psychotic behavior must be documented for Seroquel. Notes report [R11] attempts to take off immobilizer and stand up out of wheelchair. Administration of Seroquel for these actions has not helped and may contribute to confusion. If she is delirious then her abnormal thoughts and actions should be documented. She has a history of hitting nurses, grabbing staff by the neck and locking herself in her room."</p> <p>When interviewed on 6/27/13, at 8:30 a.m. the director of nursing (DON) confirmed that the facility did not have routine target behavior monitoring documented for residents who were prescribed psychoactive medications. She stated that target behaviors were monitored by nursing staff for 30 days when psychoactive medications were started or stopped. She added that nursing assistants recorded behavior occurrences in their documentation, but did not specifically address target behaviors related to the psychoactive medications that were prescribed. At 11:30 a.m., the DON stated the Behavior Incident Checklist forms were only used when an as needed medication was administered to a resident.</p> <p>On 6/27/13, at 10:40 a.m., the CP was interviewed and stated that he looks for target behaviors and uses them during his review, if they are available. When asked about any documentation of effectiveness of non-pharmacological interventions, CP stated</p>	21530			

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21530	Continued From page 5 that he had no record of that, related to R11. R10 record review, 6/26/13, revealed R10's diagnoses that included dementia with behavioral disturbances, anxiety, depression and insomnia. Review of R10's current physician orders signed 6/20/13, included Zyprexa (antipsychotic medication) 2.5 mg every evening, Ativan (antianxiety medication) 0.5 mg twice daily and Namenda (dementia/ Alzheimer's medication) 5mg twice daily. The quarterly Minimum Data Set (MDS) dated 6/13/13, revealed R10 had moderately impaired cognition and identified no behavior issues or mood symptoms were present. Review of R10's Behavior-Medication Monitoring form completed by the facility's consultant pharmacist (CP) on 4/22/13, indicated that in 3/13 Zyprexa was discontinued, but then restarted due to obsessive compulsive-type health complaints that surfaced. The CP noted a "high degree of anxiety" for R10 and recommended discontinuation of Namenda, given no indication for use was located in the record and it potentially contributed to R10's anxiety. The CP added that if R10's Zyprexa was keeping her anxiety under control, then a reduction in her Ativan, from scheduled to an as needed basis was recommended. The physician response to these recommendations noted, "No change now." The nursing staff report for these recommendations noted, "Resident's husband passed away recently. Multiple trials of changes to psych meds have been unsuccessful." Review of R10's medical record lacked identified target behaviors for the use of her psychoactive medications. The record also lacked evidence of target behavior monitoring, mood monitoring and monitoring for effectiveness of non-pharmacological interventions. In addition,	21530			

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21530	Continued From page 6 the record lacked indication for R10's use of Namenda. During interview on 6/27/13, at 9:30 a.m. DON stated R10 was on Zyprexa due to obsessive compulsive behavior, such as repeatedly stating, "bathroom, bathroom, bathroom." DON indicated her Zyprexa was discontinued in 2/13 and was restarted in 3/13, with R10 having remained stable since this restart. DON revealed R10 had been on Ativan since 2009, with a reduction from 0.5 mg three times daily to 0.5 mg twice daily on 12/13/12. Upon inquiry, DON stated the nursing staff were expected to document target behaviors, mood/behavior monitoring and non-pharmacological interventions in the nursing progress notes; however, no such documentation could be located in the record. R37, record review, 6/26/13, revealed R37's diagnoses included anxiety, depression, bipolar disorder, malaise and fatigue. Review of R37's current physician orders dated 5/20/13, included Ativan 0.5 mg three times daily and Celexa 20mg daily at bedtime, with the Celexa having been initiated on 4/26/13. The quarterly MDS dated 5/3/13, identified R37 was cognitively intact and had exhibited no behaviors. Review of R37's record lacked identification of specific anxiety symptoms to indicate the use of Ativan. The record also lacked monitoring of R37's mood, medication side effects and effectiveness of non-pharmacological interventions. During interview on 6/27/13, at 9:30 a.m. DON stated R37 had received Ativan for anxiety since prior to her readmission to the facility. DON revealed continued use of Ativan was discussed with R37's family member, who did not want it to be discontinued. Upon inquiry as to the specific anxiety symptoms R37 had been exhibiting, DON verified R37's record lacked identification of	21530			

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21530	Continued From page 7 specific anxiety related symptoms. DON confirmed pertinent documentation was lacking in R37's record, related to mood monitoring, monitoring of medication side effects and non-pharmacological intervention attempts. R46 record review 6/26/13, revealed diagnoses that included senile dementia with delusions, Alzheimer's disease, depressive disorder and aphasia. Review of R46's current physician orders included Seroquel 12.5 mg every evening. The admission MDS dated 6/3/13, identified R46 was moderately cognitively impaired and exhibited behaviors of inattention and disorganized thinking. Review of R46's Behavior-Medication Monitoring form completed by the CP on 6/19/13, noted, "Nurses report injurious behaviors of hitting, biting, grabbing neck during cares. Non med interventions not reported." CP added, "Seroquel 12.5 mg is ordered. There is history of dementia with depressive features ...No psychosis or injurious behaviors are described. If psychosis is a problem the specific symptoms must be documented for monitoring. Nurse's report [R46] hits out during cares and is injurious. This must be documented ... [R46] has tried to bite nurses, throw items off carts at nurses. Non-medication interventions have not been tried because she is a recent admit [admission]." CP recommended the facility document R46's baseline behaviors, report dose responses and document attempt to control her behaviors through non-pharmacological interventions. The nursing staff documented on this form, "Good behavior charting is in place and current." Review of R46's medical record revealed a lack of indication for the use of Seroquel, target behavior monitoring, side effect monitoring and monitoring for effectiveness of	21530			

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21530	<p>Continued From page 8</p> <p>non-pharmacological interventions. During interview on 6/27/13, at 9:30 a.m. DON stated R46 had been receiving Seroquel since prior to her admission to the facility. DON was unable to locate documentation as to why R46 was taking Seroquel and stated that sometimes family members wanted residents to take antipsychotic medications and resisted having them discontinued. DON stated pertinent documentation was lacking for R46 relating to target behavior monitoring, medication side effect monitoring and non-pharmacological intervention attempts. DON confirmed the facility's psychotropic medication monitoring system needed to be improved to ensure each medication had clear indications for use and a method for appropriate monitoring for effectiveness and adverse side effects. R9 record review, 6/26/13, indicated diagnoses that included senile dementia with depressive features, unspecified psychosis and major depressive disorder.</p> <p>Review of R9's current physician orders signed 5/9/13, included Risperdal 0.25 mg (an antipsychotic medication) for dementia with psychosis, which was discontinued on 2/26/13 and restarted on 4/16/13.</p> <p>Review of physician progress notes dated 4/16/13 revealed, R9 had been prescribed Risperdal in the past, but it was discontinued secondary to CP's recommendation. The note added, "Now pt [patient] agitated and irritable at times ... severe word finding problems ... paranoia... will restart pt on Risperdal. Pt failed GDR [gradual dose reduction]. Risperdal 0.25 mg po qd [orally daily]."</p> <p>Review of R9's record revealed Psychotropic</p>	21530			

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21530	<p>Continued From page 9</p> <p>Monitoring Following a Start, Change or Stop in Medication forms dated 4/13 and 5/13. The forms identified the medication that was given and the "area being monitored." Both forms listed behaviors, agitation and anger as being monitored for R9. No specific target behaviors were listed on the forms. No non-pharmacological interventions were listed or monitored for effectiveness. The forms revealed five episodes of agitation or anger which occurred between 4/17/13 and 5/19/13.</p> <p>Review of INFORMED CONSENT: Psychotropic Medication signed 4/16/13, revealed target behaviors for R9's use of Risperdal included yelling and running into things with his wheelchair. Non-pharmacological interventions listed included one-to-one time with staff, distraction, allowing him to express his feelings and giving him time/space as needed. The target behaviors listed on this consent form, where not listed on the Psychotropic Monitoring Following a Start, Change or Stop in Medication forms.</p> <p>Review of R9's record revealed a lack of routine monitoring for specified target behaviors and monitoring for the effectiveness of non-pharmacological interventions attempted.</p> <p>The facility's Psychotropic Drug Monitoring policy dated 9/05, read, "Consistent monitoring will be done to assess the risk/benefit relationship of psychotropic drug therapy, including the appropriateness of drug selection and dosage.</p> <p>SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could assign the interdisciplinary team to review the appropriateness of current medications for all</p>	21530			

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21530	Continued From page 10 residents, and refer any concerns to the attending physician and/or the consulting pharmacist. The quality assurance committee could randomly audit residents' drug regimens to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the	21535		

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21535	<p>Continued From page 11</p> <p>facility did not provide indications for continued use, mood monitoring, monitoring for effectiveness of non-pharmacological interventions, monitoring for target behaviors of psychoactive medications and monitoring for medication side effects, for 5 of 10 residents (R11, R10, R37, R46 and R9) reviewed for unnecessary medication use.</p> <p>Findings include:</p> <p>The facility did not routinely monitor target behaviors and did not routinely document effectiveness of non-pharmacological interventions for R11.</p> <p>Review of R11's current physician orders signed 6/13/13, included Seroquel (an antipsychotic medication), 25 milligrams (mg) daily and 50mg daily at bedtime for agitation/hallucinations and lorazepam (an anti-anxiety medication), 0.5mg three times daily. Review of R11's record, 6/25/13, revealed R11 had diagnoses that included Lewy Body dementia, depression, anxiety and hallucinations.</p> <p>Review of The Informed Consent: Psychotropic Medication form dated 1/11/13, listed Seroquel and lorazepam as medications used for R11. The form detailed agitation, self-transfers, and anger as the target behaviors related to R11's need for these medications. No ongoing, consistent monitoring of these target behaviors was located in R11's record.</p> <p>R11's current care plan dated 4/24/13, noted, "Anxiety/Behavioral symptoms-Resident wanting to walk and stand without assistance/wandering in facility/uncertainty of what to do." Several non-pharmacological interventions were listed,</p>	21535			

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21535	<p>Continued From page 12</p> <p>such as taking R11 for a walk or offering green tea and finger food snacks. Several Behavior Incident Checklist forms were included in R11's record. These forms were completed only when an "as needed" medication was administered to a resident. The Behavior Incident Checklist forms were the sole form of documentation for the effectiveness of non-pharmacological interventions for R11.</p> <p>When interviewed on 6/27/13, at 8:30 a.m. the director of nursing (DON) confirmed that the facility did not have routine target behavior monitoring documented for residents who were prescribed psychoactive medications. She stated that target behaviors were monitored by nursing staff for 30 days when psychoactive medications were started or stopped. She added that nursing assistants recorded behavior occurrences in their documentation, but did not specifically address target behaviors related to the psychoactive medications that were prescribed. At 11:30 a.m., the DON verified the Behavior Incident Checklist forms were only used when an as needed medication was administered to a resident</p> <p>Review of R10's current physician orders signed 6/20/13, included Zyprexa (antipsychotic medication) 2.5 mg every evening, Ativan (antianxiety medication) 0.5 mg twice daily and Namenda (dementia/ Alzheimer's medication) 5mg twice daily. The quarterly Minimum Data Set (MDS) dated 6/13/13, revealed R10 had moderately impaired cognition and identified no behavior issues or mood symptoms were present. Review of the record, 6/26/13, revealed R10 diagnoses included dementia with behavioral disturbances, anxiety, depression and insomnia.</p> <p>Review of R10's Behavior-Medication Monitoring form completed by the facility's consultant</p>	21535		

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21535	Continued From page 13 pharmacist (CP) on 4/22/13, indicated that in 3/13 Zyprexa was discontinued, but then restarted due to obsessive compulsive-type health complaints that surfaced. The CP noted a "high degree of anxiety" for R10 and recommended discontinuation of Namenda, given no indication for use was located in the record and it potentially contributed to R10's anxiety. The CP added that if R10's Zyprexa was keeping her anxiety under control, then a reduction in her Ativan, from scheduled to an "as needed" basis was recommended. The physician response to these recommendations noted, "No change now." The nursing staff report for these recommendations noted, "Resident's husband passed away recently. Multiple trials of changes to psych meds have been unsuccessful." Review of R10's medical record lacked identified target behaviors for the use of her psychoactive medications. The record also lacked evidence of target behavior monitoring, mood monitoring and monitoring for effectiveness of non-pharmacological interventions. In addition, the record lacked indication for R10's use of Namenda. During interview on 6/27/13, at 9:30 a.m. DON stated R10 was on Zyprexa due to obsessive compulsive behavior, such as repeatedly stating, "bathroom, bathroom, bathroom." DON indicated her Zyprexa was discontinued in 2/13 and was restarted in 3/13, with R10 having remained stable since this restart. DON revealed R10 had been on Ativan since 2009, with a reduction from 0.5 mg three times daily to 0.5 mg twice daily on 12/13/12. Upon inquiry, DON stated the nursing staff were expected to document target behaviors, mood/behavior monitoring and non-pharmacological interventions in the nursing progress notes; however, no such documentation could be located in the record.	21535			

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21535	<p>Continued From page 14</p> <p>Review of R37's current physician orders dated 5/20/13, included Ativan 0.5 mg three times daily and Celexa 20mg daily at bedtime, with the Celexa having been initiated on 4/26/13. The quarterly MDS dated 5/3/13, identified R37 was cognitively intact and had exhibited no behaviors. Review of the record, 6/26/13, revealed R37's diagnoses included anxiety, depression, bipolar disorder, malaise and fatigue.</p> <p>Review of R37's record lacked identification of specific anxiety symptoms to indicate the use of Ativan. The record also lacked monitoring of R37's mood, medication side effects and effectiveness of non-pharmacological interventions.</p> <p>During interview on 6/27/13, at 9:30 a.m. DON stated R37 had received Ativan for anxiety since prior to her readmission to the facility. DON revealed continued use of Ativan was discussed with R37's family member, who did not want it to be discontinued. Upon inquiry as to the specific anxiety symptoms R37 had been exhibiting, DON verified R37's record lacked identification of specific anxiety related symptoms. DON confirmed pertinent documentation was lacking in R37's record, related to mood monitoring, monitoring of medication side effects and non-pharmacological intervention attempts.</p> <p>Review of R46's current physician orders included Seroquel 12.5 mg every evening. The admission MDS dated 6/3/13, identified R46 was moderately cognitively impaired and exhibited behaviors of inattention and disorganized thinking. Review of the record, 6/26/13 identified R46's diagnoses included senile dementia with delusions, Alzheimer's disease, depressive disorder and aphasia.</p> <p>Review of R46's Behavior-Medication Monitoring</p>	21535			

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21535	Continued From page 15 form completed by the CP on 6/19/13, noted, "Nurses report injurious behaviors of hitting, biting, grabbing neck during cares. Non med interventions not reported." CP added, "Seroquel 12.5 mg is ordered. There is history of dementia with depressive features ...No psychosis or injurious behaviors are described. If psychosis is a problem the specific symptoms must be documented for monitoring. Nurse's report [R46] hits out during cares and is injurious. This must be documented ... [R46] has tried to bite nurses, throw items off carts at nurses. Non-medication interventions have not been tried because she is a recent admit [admission]." CP recommended the facility document R46's baseline behaviors, report dose responses and document attempt to control her behaviors through non-pharmacological interventions. The nursing staff documented on this form, "Good behavior charting is in place and current." Review of R46's medical record revealed a lack of indication for the use of Seroquel, target behavior monitoring, side effect monitoring and monitoring for effectiveness of non-pharmacological interventions. During interview on 6/27/13, at 9:30 a.m. DON stated R46 had been receiving Seroquel since prior to her admission to the facility. DON was unable to locate documentation as to why R46 was taking Seroquel and stated that sometimes family members wanted residents to take antipsychotic medications and resisted having them discontinued. DON stated pertinent documentation was lacking for R46 relating to target behavior monitoring, medication side effect monitoring and non-pharmacological intervention attempts. DON confirmed the facility's psychotropic medication monitoring system needed to be improved to ensure each medication had clear indications for use and a	21535			

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21535	<p>Continued From page 16</p> <p>method for appropriate monitoring for effectiveness and adverse side effects.</p> <p>Review of R9's current physician orders signed 5/9/13, included Risperdal 0.25 mg (an antipsychotic medication) for dementia with psychosis, which was discontinued on 2/26/13 and restarted on 4/16/13. Review of the record revealed R9's diagnoses included senile dementia with depressive features, unspecified psychosis and major depressive disorder.</p> <p>Review of physician progress notes dated 4/16/13 revealed, R9 had been prescribed Risperdal in the past, but it was discontinued secondary to CP's recommendation. The note added, "Now pt [patient] agitated and irritable at times ... severe word finding problems ... paranoia... will restart pt on Risperdal. Pt failed GDR [gradual dose reduction]. Risperdal 0.25 mg po qd [orally daily]."</p> <p>Review of R9's record revealed Psychotropic Monitoring Following a Start, Change or Stop in Medication forms dated 4/13 and 5/13. The forms identified the medication that was given and the "area being monitored." Both forms listed behaviors, agitation and anger as being monitored for R9. No specific target behaviors were listed on the forms. No non-pharmacological interventions were listed or monitored for effectiveness. The forms revealed five episodes of agitation or anger which occurred between 4/17/13 and 5/19/13.</p> <p>Review of INFORMED CONSENT: Psychotropic Medication signed 4/16/13, revealed target behaviors for R9's use of Risperdal included yelling and running into things with his wheelchair.</p>	21535			

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21535	Continued From page 17 Non-pharmacological interventions listed included one-to-one time with staff, distraction, allowing him to express his feelings and giving him time/space as needed. The target behaviors listed on this consent form, where not listed on the Psychotropic Monitoring Following a Start, Change or Stop in Medication forms. Review of R9's record revealed a lack of routine monitoring for specified target behaviors and monitoring for the effectiveness of non-pharmacological interventions attempted. The facility's Psychotropic Drug Monitoring policy dated 9/05, read, "Consistent monitoring will be done to assess the risk/benefit relationship of psychotropic drug therapy, including the appropriateness of drug selection and dosage. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could re-educate the involved staff as to proper procedure psychoactive medication use and monitoring. She could also conduct periodic audits to insure staff compliance with this rule is in place. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21535			
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	21540			

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21540	Continued From page 18 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 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 interview and document review, the facility did not provide indications for continued use, mood monitoring, monitoring for effectiveness of non-pharmacological interventions, monitoring for target behaviors of psychoactive medications and monitoring for medication side effects. In addition, the consulting pharmacist failed to advise the facility regarding lack of behavior monitoring and failed to make recommendations to the facility regarding irregularities identified, related to indications for continued use, mood monitoring, monitoring for effectiveness of non-pharmacological interventions, monitoring for target behaviors of psychoactive medications and monitoring for medication side effects, for 5 of 10 residents (R11, R10, R37, R46 and R9) reviewed for unnecessary medication use. Findings include:	21540		

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21540	<p>Continued From page 19</p> <p>Record review, on 6/25/13, revealed R11's diagnoses included Lewy Body dementia, depression, anxiety and hallucinations.</p> <p>Review of R11's current physician orders signed 6/13/13, included Seroquel (an antipsychotic medication), 25 milligrams (mg) daily and 50mg daily at bedtime for agitation/hallucinations and lorazepam (an anti-anxiety medication), 0.5mg three times daily.</p> <p>The Informed Consent: Psychotropic Medication form dated 1/11/13, listed Seroquel and lorazepam as medications used for R11. The form detailed agitation, self-transfers, and anger as the target behaviors related to R11's need for these medications. No ongoing, consistent monitoring of these target behaviors was located in R11's record.</p> <p>R11's current care plan dated 4/24/13, noted, "Anxiety/Behavioral symptoms-Resident wanting to walk and stand without assistance/wandering in facility/uncertainty of what to do." Several non-pharmacological interventions were listed, such as taking R11 for a walk or offering green tea and finger food snacks. Several Behavior Incident Checklist forms were included in R11's record. These forms were completed only when an as needed medication was administered to a resident. The Behavior Incident Checklist forms were the sole form of documentation for the effectiveness of non-pharmacological interventions for R11.</p> <p>Review of Behavior-Medication Monitoring form completed by the facility's consultant pharmacist (CP) dated 4/22/13, noted, "Agitation is not an accepted indication for using either Seroquel or</p>	21540			

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21540	<p>Continued From page 20</p> <p>lorazepam. Injurious or psychotic behavior must be documented for Seroquel. Notes report [R11] attempts to take off immobilizer and stand up out of wheelchair. Administration of Seroquel for these actions has not helped and may contribute to confusion. If she is delirious then her abnormal thoughts and actions should be documented. She has a history of hitting nurses, grabbing staff by the neck and locking herself in her room."</p> <p>When interviewed on 6/27/13, at 8:30 a.m. the director of nursing (DON) confirmed that the facility did not have routine target behavior monitoring documented for residents who were prescribed psychoactive medications. She stated that target behaviors were monitored by nursing staff for 30 days when psychoactive medications were started or stopped. She added that nursing assistants recorded behavior occurrences in their documentation, but did not specifically address target behaviors related to the psychoactive medications that were prescribed. At 11:30 a.m., the DON stated the Behavior Incident Checklist forms were only used when an as needed medication was administered to a resident.</p> <p>On 6/27/13, at 10:40 a.m., the CP was interviewed and stated that he looks for target behaviors and uses them during his review, if they are available. When asked about any documentation of effectiveness of non-pharmacological interventions, CP stated that he had no record of that, related to R11.</p> <p>R10 record review, 6/26/13, revealed R10's diagnoses that included dementia with behavioral disturbances, anxiety, depression and insomnia. Review of R10's current physician orders signed 6/20/13, included Zyprexa (antipsychotic</p>	21540			

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21540	Continued From page 21 medication) 2.5 mg every evening, Ativan (antianxiety medication) 0.5 mg twice daily and Namenda (dementia/ Alzheimer's medication) 5mg twice daily. The quarterly Minimum Data Set (MDS) dated 6/13/13, revealed R10 had moderately impaired cognition and identified no behavior issues or mood symptoms were present. Review of R10's Behavior-Medication Monitoring form completed by the facility's consultant pharmacist (CP) on 4/22/13, indicated that in 3/13 Zyprexa was discontinued, but then restarted due to obsessive compulsive-type health complaints that surfaced. The CP noted a "high degree of anxiety" for R10 and recommended discontinuation of Namenda, given no indication for use was located in the record and it potentially contributed to R10's anxiety. The CP added that if R10's Zyprexa was keeping her anxiety under control, then a reduction in her Ativan, from scheduled to an as needed basis was recommended. The physician response to these recommendations noted, "No change now." The nursing staff report for these recommendations noted, "Resident's husband passed away recently. Multiple trials of changes to psych meds have been unsuccessful." Review of R10's medical record lacked identified target behaviors for the use of her psychoactive medications. The record also lacked evidence of target behavior monitoring, mood monitoring and monitoring for effectiveness of non-pharmacological interventions. In addition, the record lacked indication for R10's use of Namenda. During interview on 6/27/13, at 9:30 a.m. DON stated R10 was on Zyprexa due to obsessive compulsive behavior, such as repeatedly stating, "bathroom, bathroom, bathroom." DON indicated her Zyprexa was discontinued in 2/13 and was	21540			

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21540	Continued From page 22 restarted in 3/13, with R10 having remained stable since this restart. DON revealed R10 had been on Ativan since 2009, with a reduction from 0.5 mg three times daily to 0.5 mg twice daily on 12/13/12. Upon inquiry, DON stated the nursing staff were expected to document target behaviors, mood/behavior monitoring and non-pharmacological interventions in the nursing progress notes; however, no such documentation could be located in the record. R37, record review, 6/26/13, revealed R37's diagnoses included anxiety, depression, bipolar disorder, malaise and fatigue. Review of R37's current physician orders dated 5/20/13, included Ativan 0.5 mg three times daily and Celexa 20mg daily at bedtime, with the Celexa having been initiated on 4/26/13. The quarterly MDS dated 5/3/13, identified R37 was cognitively intact and had exhibited no behaviors. Review of R37's record lacked identification of specific anxiety symptoms to indicate the use of Ativan. The record also lacked monitoring of R37's mood, medication side effects and effectiveness of non-pharmacological interventions. During interview on 6/27/13, at 9:30 a.m. DON stated R37 had received Ativan for anxiety since prior to her readmission to the facility. DON revealed continued use of Ativan was discussed with R37's family member, who did not want it to be discontinued. Upon inquiry as to the specific anxiety symptoms R37 had been exhibiting, DON verified R37's record lacked identification of specific anxiety related symptoms. DON confirmed pertinent documentation was lacking in R37's record, related to mood monitoring, monitoring of medication side effects and non-pharmacological intervention attempts. R46 record review 6/26/13, revealed diagnoses that included senile dementia with delusions,	21540			

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21540	Continued From page 23 Alzheimer's disease, depressive disorder and aphasia. Review of R46's current physician orders included Seroquel 12.5 mg every evening. The admission MDS dated 6/3/13, identified R46 was moderately cognitively impaired and exhibited behaviors of inattention and disorganized thinking. Review of R46's Behavior-Medication Monitoring form completed by the CP on 6/19/13, noted, "Nurses report injurious behaviors of hitting, biting, grabbing neck during cares. Non med interventions not reported." CP added, "Seroquel 12.5 mg is ordered. There is history of dementia with depressive features ...No psychosis or injurious behaviors are described. If psychosis is a problem the specific symptoms must be documented for monitoring. Nurse's report [R46] hits out during cares and is injurious. This must be documented ... [R46] has tried to bite nurses, throw items off carts at nurses. Non-medication interventions have not been tried because she is a recent admit [admission]." CP recommended the facility document R46's baseline behaviors, report dose responses and document attempt to control her behaviors through non-pharmacological interventions. The nursing staff documented on this form, "Good behavior charting is in place and current." Review of R46's medical record revealed a lack of indication for the use of Seroquel, target behavior monitoring, side effect monitoring and monitoring for effectiveness of non-pharmacological interventions. During interview on 6/27/13, at 9:30 a.m. DON stated R46 had been receiving Seroquel since prior to her admission to the facility. DON was unable to locate documentation as to why R46 was taking Seroquel and stated that sometimes family members wanted residents to take	21540			

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21540	<p>Continued From page 24</p> <p>antipsychotic medications and resisted having them discontinued. DON stated pertinent documentation was lacking for R46 relating to target behavior monitoring, medication side effect monitoring and non-pharmacological intervention attempts. DON confirmed the facility's psychotropic medication monitoring system needed to be improved to ensure each medication had clear indications for use and a method for appropriate monitoring for effectiveness and adverse side effects. R9 record review, 6/26/13, indicated diagnoses that included senile dementia with depressive features, unspecified psychosis and major depressive disorder.</p> <p>Review of R9's current physician orders signed 5/9/13, included Risperdal 0.25 mg (an antipsychotic medication) for dementia with psychosis, which was discontinued on 2/26/13 and restarted on 4/16/13.</p> <p>Review of physician progress notes dated 4/16/13 revealed, R9 had been prescribed Risperdal in the past, but it was discontinued secondary to CP's recommendation. The note added, "Now pt [patient] agitated and irritable at times ... severe word finding problems ... paranoia... will restart pt on Risperdal. Pt failed GDR [gradual dose reduction]. Risperdal 0.25 mg po qd [orally daily]."</p> <p>Review of R9's record revealed Psychotropic Monitoring Following a Start, Change or Stop in Medication forms dated 4/13 and 5/13. The forms identified the medication that was given and the "area being monitored." Both forms listed behaviors, agitation and anger as being monitored for R9. No specific target behaviors were listed on the forms. No</p>	21540			

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21540	<p>Continued From page 25</p> <p>non-pharmacological interventions were listed or monitored for effectiveness. The forms revealed five episodes of agitation or anger which occurred between 4/17/13 and 5/19/13.</p> <p>Review of INFORMED CONSENT: Psychotropic Medication signed 4/16/13, revealed target behaviors for R9's use of Risperdal included yelling and running into things with his wheelchair. Non-pharmacological interventions listed included one-to-one time with staff, distraction, allowing him to express his feelings and giving him time/space as needed. The target behaviors listed on this consent form, where not listed on the Psychotropic Monitoring Following a Start, Change or Stop in Medication forms.</p> <p>Review of R9's record revealed a lack of routine monitoring for specified target behaviors and monitoring for the effectiveness of non-pharmacological interventions attempted.</p> <p>The facility's Psychotropic Drug Monitoring policy dated 9/05, read, "Consistent monitoring will be done to assess the risk/benefit relationship of psychotropic drug therapy, including the appropriateness of drug selection and dosage. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could review the need for medication monitoring with the licensed staff including the State and federal regulations. She could randomly audit resident medication orders to ensure that medications were utilized in accordance with accepted standards, and to ensure medications were monitored for potential adverse effects.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	21540			