

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 26, 2019

Administrator Riverview Hospital & Nursing Home 323 South Minnesota Crookston, MN 56716

RE: Project Number S5251041, H5251017, H5251018 and H5251019C

Dear Administrator:

On February 8, 2019, we informed you that the following enforcement remedy was being imposed:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 25, 2019 remain in effect.

Also on February 8, 2019, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) the following enforcement remedy:

• Civil money penalty. (42 CFR 488.430 through 488.444)

On March 6, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 15, 2019 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 January 4, 2019 and an extended survey completed on January 23, 2019. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 15, 2019. We have determined, based on our visit, that your facility has corrected as of March 15, 2019.

As a result of the revisit findings:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective March 25, 2019 be rescinded as of March 15, 2019. (42 CFR 488.417 (b))

However, as we notified you in our letter of January 18, 2019, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 23, 2019.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights. Riverview Hospital & Nursing Home March 26, 2019 Page 2

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered February 8, 2019

Administrator Riverview Hospital & Nursing Home 323 South Minnesota Crookston, MN 56716

RE: Project Number S5251041, H5251017, H5251018 and H5251019C

Dear Administrator:

On January 18, 2019, we informed you that the following enforcement remedy was being imposed:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 25, 2019.

You were also notified in our letter dated January 18, 2019 that this Department recommened to the Centers for Medicare and Medicaid Services (CMS) the following enforcement remedy:

• Civil money penalty. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on January 4, 2019 that included an investigation of complaint number H5251017 and H5251018. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On January 23, 2019, an extended survey was completed at your facility by the Minnesota Department of Health to investigate complaint H5251019C number 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On February 24, 2019, the situation of immediate jeopardy to potential health and safety cited at F 689 was removed. However, continued non-compliance remains at the lower scope and severity of G.

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 25 2019, will remainin effect.

This Department is also continuing to recommend that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

• Civil money penalty, (42 CFR 488.430 through 488.444).

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 25 2019, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 25 2019, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

As we notified you in our letter of January 18, 2019, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 23, 2019. The change in date is due to the extended survey that was completed on January 23, 2019.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with one of the follwoing: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care,

as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Riverview Hospital & Nursing Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective January 23, 2019. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

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 July 4, 2019 (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.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services Departmental Appeals Board, MS 6132 Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you

have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services Departmental Appeals Board, MS 6132 Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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.

Sincerely,

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

cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES		· ·		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-	0	MB NO	. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	СОМ	E SURVEY IPLETED
		245251	B. WING			C 23/2019
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	20/2010
	EW HOSPITAL & NUF			323 SOUTH MINNESOTA		
RIVERVI				CROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 00	00		
	H5251019C was co Department of Hea complaint was subs resulted in an Imme due to the facility's comprehensive pos	st fall assessments and tions to minimize further falls				
		y was conducted by the nent of Health on 1/23/19,				
	signature is not req page of the CMS-2	ed in ePOC and therefore a uired at the bottom of the first 567 form. Electronic POC will be used as bliance.				
F 689	revisit of your facilit that substantial con has been attained i verification.	acceptable POC an on-site y will be conducted to validate npliance with the regulations n accordance with your azards/Supervision/Devices	F 68	39		2/18/19
	CFR(s): 483.25(d)(_, ,
	supervision and ass accidents.	resident receives adequate sistance devices to prevent NT is not met as evidenced				
LABORATOR	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
	ically Signed					02/18/2019

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.

		AND HUMAN SERVICES				FORM	02/19/2019 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE	E SURVEY PLETED
		245251	B. WING				23/2019
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RIVERVII	EW HOSPITAL & NUF	RSING HOME			23 SOUTH MINNESOTA ROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	review, the facility facility facility	ge 1 tion, interview and document ailed to ensure resident safety n increased risk for falls and	F 6	89	Facility timely submits this response plan of correction pursuant to Feder State law requirements. This respo	al and	
	the potential for ser impairment to 1 of 3 falls who was identia dementia with imput agitation which resu attempts. On 1/16/7 to self transfer with subsequently fell with fractures and anoth compression fractu	ious harm, injury, or 3 residents (R1) reviewed for fied as at risk for falls, had ilsive behavior, anxiety and ulted in repeated self transfer 19, R1 had repeated attempts out adequate supervision and hich resulted in pelvic her fall which resulted in spinal res at lumbar spine (L1, L2)			and plan of correction are not admiss or an agreement, that a deficiency e or that the statement of a deficiency correctly cited or factually based and not to be construed as an admission against the interest of the facility, the administrator, or any employees, ag or other individuals who participated drafting or who may be discussed on otherwise identified in the same.	ssions, exists v was d it is n e jents, l in the	
	an IJ for R1. In add implement alternati the risk for falls for also identified at ris The immediate jeop	oardy began on 1/6/19, at 6:15			January 24, 2019 Problem: R1 is an 81-yer old female resident residing in our Memory Car Skilled-Nursing facility with the follow	re wing	
	allowed R1 to be ur R1 attempted to se which resulted in pe administrator and d notified of the IJ on was removed on 1/ remained at the low	identified R1 was agitated yet nattended in the dining room. If transfer and sustained a fall elvic fractures. The irector of nursing (DON) were 1/23/19, at 3:18 p.m. The IJ 24/19, but noncompliance ver scope and severity of G - cated actual harm had			diagnoses: Major depressive disord Presence of right artificial hip joint, Alzhiemer's disease, Dementia in ot diseases classified elsewhere with behavioral disturbance, Anxiety Diso Delusional disorder(History of Hallucinations), osteoporosis, RLS, hypothyroidism, GERD, joint paint.	ther	
	occurred with poter harm that is not imr Findings include:	ntial for more than minimal nediate jeopardy.			Review of Falls: R1 has experience frequent falls, which most recently resulted in a fracture to the pubic rat from a fall in the dining room on Jan 6, 2010, R1 has a repeat fall when	mus luary	
	R1 had diagnoses disease, anxiety dis	port dated 1/23/19, indicated which included Alzheimer's sorder, depression, sional disorder, dementia with			6, 2019. R1 has a repeat fall when a slid out of her recliner on January 12 2019. R1 was admitted to the hospi 01/12/19 for cholecystitis where ima obtained for cholecystitis showed ne	2, ital on iging	

Facility ID: 00470

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		I AND HUMAN SERVICES E & MEDICAID SERVICES					APPROVE 0938-039
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE	SURVEY PLETED
		245251	B. WING			C 01/2	; 23/2019
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•=	
RIVERVI	EW HOSPITAL & NUF	RSING HOME			23 SOUTH MINNESOTA ROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETIO DATE
F 689	Continued From pa	age 2	F 6	89			
	behavioral disturba syndrome.	nce and restless leg			compression fractures to L1 and L2 a T11. R1 has had 18 falls in the past year.		
	R1's quarterly Minimum Data Set (MDS) dated 10/7/18, indicated R18 had severe cognitive impairment and required extensive assistance of one to two staff for all activities of daily living. The MDS also indicated R1 had experienced one fall without injury and one fall with major injury (bone fracture, joint dislocation, closed head injury with altered consciousness, subdural hematoma) since the prior assessment. R1's Falls Care Area Assessment (CAA) dated 4/29/18, indicated R18 used antidepressant,				The following are identified risk facto Recent history of falls. Behavior, hx fracture, environmental(Agitation wit noise), medication side effects, ment status,(see diagnosis), visual impairr (wears glasses), gait disturbance wit current pubic fracture (weight bearing tolerated), catheter. R1 needs freque redirection when attempting to stand has periods of agitation and anxiety documented behaviors of screaming crying, pounding on walls/doors. R1	of th tal ment th g as esnt l. R1 with J, has	
	medications were e experienced falls. falls). R1 used a w assistance of two fe wheelchair due to r reminders and cue tried to self transfer falls, usually withou March, resulted in a	bain medications. R1's effective but R1 had Fall risk was 22 (high risk for valker and required extensive or ambulation and also used a mobility issues. R1 needed s for wheelchair use and had r a number of times and had ut injury. However, one fall in a compression fracture of the lent bed alarm and a night light d by her bed.			had recent medication adjustments to primary care provider (antidepressar changes). In discussing resident with primary care provider, Dr. Fashoro, H notes resident has long-standing hist psychotic disorder and was previous behavioral health unit in Bemidji, MN before being admitted to our Care Ce on 11/7/17. R1 does respond to redirection, reassurance and re-approaching when she is having the agitated/anxious episodes. Currently	nt h tory of ly in a l enter hese y	
	R1's Care Plan rev was at risk for fallin cognition and weak implement the follo -Bed alarm on to al -May leave gait bel	ised 10/10/18, indicated R1 ng related to dementia, kness and directed staff to			seeking Pharmacy opinion on medic added for pain management related fracture and increased fall risk. R1's family has noted that R1 appears to agitated easily when other residents also agitated. When possible, remov R1 away from other agitated resident appears to be helpful.	ations to get are ving	
	get there.	ders not to ambulate/transfer			NEW and IMMEDIATE INTERVENT FOR R1/FALLS: Specific to R1 - Immediate review of		

Facility ID: 00470

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	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CONSTRUCTION		0938-039 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:				PLETED
						С
		245251	B. WING		01/2	23/2019
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
RIVERVI	EW HOSPITAL & NUP	RSING HOME		323 SOUTH MINNESOTA CROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
F 689	Continued From pa	ige 3	F6	689		
	-Keep call light in re bathroom to be on -Obtain physical the training, toning, pos training, mobility de -Provide an enviror	each at all times. Night light in at all times. erapy (PT) consult for strength sitioning, transfer training, gait evices, as needed. ment free of clutter.		meds by Pharmacist d/t recer discharge d/t high risk for falls med changes. Specific to R1 - Updated Care all interventions and review w report. Staff signature require	e Plan with th staff at	
	R1's clinical record information:	revealed the following		review. (As above.) Specific to R1 - Inter-Disciplin	arv Team.	
	12:18 p.m. indicate R1 was noted to be and hitting a door v RN-A had directed)/nurse's note dated 1/6/19, at d R1 was agitated and yelling. e yelling "I want to go home" vith the palm of her hand. the staff to call R1's family if ued. A subsequent PN at		(IDT), met on 1/24/19 to discu current intervention and discu interventions. Input was gath staff on suggestions/concerns R1's current high-fall risk.	iss R1's ss any new ered from	
	12:25 p.m. indicate family and requeste member (FM)-B dir of the memory care her. The staff repo accommodate FM- issues." Another PI talked to FM-B on t	d the staff had called the ed them to visit. Family rected the staff to wheel R1 off e unit in an attempt to calm rted they were unable to B's request due to "staff N at 12:56 p.m. indicated R1 he phone and had calmed . FM-A visited R1 at the facility.		Specific to R1 - Updated R1's to reflect the new intervention below, Specific to R1. NEW: Charge Nurse to imple 15-minute rounding to resider agitated/crying/weeping episo provide support, diversion, rea reassurance. Capture roundi documenting on checklist. Ch filed/scanned into resident's c	s listed ment every it during des to direction and ng by necklist to be	
	dated 1/6/19, at 6:1 on the floor in the of move R1's right leg R1 was transferred evaluation. The Po 1/6/19, fall dated 1/ risk for falls and R1 of the fall on 1/6/19 R1's plan to preven	all report (incident report) 5 p.m. indicated R1 was found lining room. Staff attempted to and she complained of pain. to the hospital for further ost Fall Assessment for the 7/19, indicated R1 was at high had been agitated at the time the assessment indicated the falls was to make ted out of the dining room		Specific to R1 - Educate/inser all above actions. NEW INTERVENTIONS: Car team informed of all immediat interventions at morning hudd 1/24/19 and will continue to be forward to oncoming staff by I Nurse. Information on 15-mir rounding placed in communic and will continue to be reported	e Center te le on e reported DON/Charge nute ation book	

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLI		(X3) DATE	0938-039 SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG _		COMF	PLETED
						C	2
		245251	B. WING			01/2	23/2019
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	RSING HOME			23 SOUTH MINNESOTA ROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 689	Continued From pa	ige 4	F 68	89			
	R1's Hospital Disch indicated R1 had su inferior pubic ramit diagnosed with a un to return to the nurse bear weight as tole medications were p antianxiety medicat and an antibiotic fo tract infection. Rev revealed upon R1's comprehensive fall implementation of it completed following fractures. In addition included revisions f PN dated 1/12/19, a "extremely anxious given as needed pather recliner. R1 did fall, however, was the room due to facility laboratory levels from to R1's yellowish (ja admitted to the hosping report dated 1/12/1 had slid out of her in have pain but was a due to abnormal lal any assessment of Tracking/five day in related to the 1/6/19 facility to the State indicated R1 had si	arge Summary dated 1/9/19, ustained right superior and (pelvis) fractures and had been rinary tract infection. R1 was sing facility and was allowed to rated, as needed pain prescribed (Percocet), an tion (lorazepam) for agitation r the treatment of the urinary view of R1's clinical record a hospital return, a new assessment and the nterventions was not g the diagnosis of the in, R1's care plan had not following the hospital return. at 5:12 p.m. indicated R1 was , restless and weepy." R1 was ain medications and slid out of d not express pain during the ransferred to the emergency 's notification of abnormal om a previous blood draw due aundice) appearance. R1 was pital. The Safety Events-Fall 9, at 5:20 p.m. indicated R1 recliner in her room, did not sent to the emergency room b values. The report lacked the fall. An Incident westigation form which was 9, and was submitted by the Agency dated 1/12/19, ustained a fall 1/6/19, while at in pelvic fractures. The		09	DEFICIENCY AS IT RELATES TO T INDIVIDUAL: Care Plan Updated to Following Interventions: - Environment free of clutter - Recent Physical Therapy consult - Recent Occupational Therapy con - Verbal reminders not to ambulate/transfer without assist - May leave gait belt on loosely - Bed alarm on bed - Bed in lowest position - Mats on floor by bed - Mattress with raised edge - Provide a quiet, non-hurried enviro free of background noise and distra - Immediate Pharmacy consult due recent discharge from hospital with medications on high-fall risk resider - Assisting resident as one of the first of the dining room to nurses station when meals are finished. - During episodes of crying, weeping and/or anxiety, charge nurse to imp every 15-minute rounding on reside NAR. - Antirollback device to wheelchair - Room close to Nurses station Problem Goal Approach Discipline (plan copy) Resident at risk for falling R/T Dementia/cognition/weakness - Pharmacy consult on medications recent med changes with hospitaliza to assess changes in risk for falls. - Antirollback to wheelchair	sult onment ctions. to new nt. st out area g, lement nt by care due to	

Facility ID: 00470

		& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	Сом	E SURVEY PLETED
		245251	B. WING				C
	PROVIDER OR SUPPLIER	245251	D. WING	-	STREET ADDRESS, CITY, STATE, ZIP CODE	01/2	23/2019
	EW HOSPITAL & NUF	RSING HOME		:	323 SOUTH MINNESOTA CROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 689	Continued From pa	ae 5	F6	689			
	standing/walking. I interest when restler record lacked ident cause/unmet need identification of inter risk of further falls. R1's Hospital Disch at 1:23 p.m. indicat gallbladder infection elevated liver function surgical candidate a intravenous antibion pain management of patches. R1 returner hospitalized, a Cat which revealed new fractures. A PN dated 1/16/19 facility and a person placed in the recliner updated to reflect the On 1/22/19, from 4 continuously observe recliner. The recliner personal alarm. A p was seated next to On 1/22/19, at 4:52 stated R1's family h companion to sit wit Shortly there-after,	Diversional activities of her ess." However, R1's clinical ification of the root resulting in the falls and ervention(s) to minimize the harge Summary dated 1/16/19, ed R1 was diagnosed with a n without gall stones and ions, however, R1 was not a and was treated with tics while at the hospital. R1's was changed to Fentanyl ed to the facility. While Scan (CT) was performed vly diagnosed L1, L2 and T11 0, indicated R1 returned to the nal silent chair alarm was er. R1's care plan was not he new intervention. :00 p.m. to 7:45 p.m. R1 was ved in her room, seated in the er was equipped with a silent bersonal companion (PC)-A her. :2 p.m. registered nurse (RN)-A had hired the personal th R1 a few hours a day. the DON stated R1's family to stay in her room and they			 Due to resident frequent attempts stand while dining, ensure safety or resident by assisting as one of the of dining room to Nurses station ar where staff are present during transporting of residents from dinin room. During episodes of agitation, cryin weeping and/or anxiety, Charge Natimplement every 15-minute roundin resident by NAR and/or Nursing to safety from falls by providing reases redirection, support, and/or diversion resident appears calm. Family currequesting resident remain in room healing fractures. Room close to Nurses station. Scoop mattress (raised edges), or Per family request, air mattress on comfort due to current fracture. Refer an eed for air mattress when fracture - Bed alarm on bed to alert staff of movement. May leave gait belt on loosely as resident gets up unexpectedly and moving before staff can close-the distance to reach the resident. Provide verbal reminders not to ambulate/transfer without assistant of all times when in resident room. Night light in bathroom to be left of times. Obtain PT consult for _strength trattoning, mobility devices, PRN). Provide an environment free of close. 	f first out rea ng ng, urse to ng on ensure surance, on until rently n with on bed. bed for eassess e heals. starts ce. reach at on at all ining, g, gait	
		eed practical nurse (LPN)-A story of attempting to transfer			AUDITING SYSTEM BY DIRECTO	OR OF	

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				T.D.			0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X	COMF	E SURVEY PLETED
		245251	B. WING			01/2	C 23/2019
	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	01/2	23/2019
	NOVIDEN ON CONT EIER				23 SOUTH MINNESOTA		
RIVERVI	EW HOSPITAL & NUP	RSING HOME			ROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 689	Continued From pa	age 6	Fe	89			
F 689	on her own. As the when a resident fel for injury, monitore checks if the reside stated R1 had a lov and personal silent recliner. The staff frequently, howeve "frequent" checks. receive every two h were to document two hours. LPN-A directed the staff to -At 5:50 p.m. nursin observed to deliver PC-A remained wit with the meal. -At 6:28 p.m. NA-A while at the facility on 1/6/19. NA-A st room on the evenir escorting other res when she saw R1 a from a dining room	age 6 e charge nurse, LPN-A stated II, she assessed the resident d vital signs and neurological ent had hit their head. LPN-A w bed, fall mats next to the bed a alarms on the bed and were to check on R1 r, they did not document the LPN-A stated R1 was to nour monitoring and the staff any care provided to R1 every stated the family members had b keep R1 in her room. Ing assistant (NA)-A was a meal tray to R1's room. h the resident and assisted R1 e stated R1 had sustained falls and had fractured her pelvis tated R1 had been in the dining og of 1/6/19, as NA-A was idents out of the dining room attempt to stand up and fall chair. NA-A stated she was o R1 to guide her back into the	F 6	\$89	NURSING TO MONITOR WEEKLY REVIEW OF ALL RESIDENTS OF R FOR FALLS, INCLUSIVE OF R1. DA STAFF HUDDLES TO PROVIDE CURRENT INFORMATION ON ANY RESIDENT CHANGES THAT WOUL INDICATE A POTENTIAL FOR INCREASED FALL RISK, AND NEW SOLUTIONS BASED ON IDENTIFIE RESIDENTS, AS IDENTIFIED ABOV TO UPDATED CARE PLAN. POLICIES WERE REVIEWED AND UPDATED. SEE ATTACHMENTS A,E HOW TO MONITOR FOING FORWA RN/DON to do care plan audits, as no above, at post-fall review (day 7). Wi audit care plan, progress notes and communication of any recommended intervention at this time. Newly implemented root-cause analy with IDT team with every fall daily. RN/DON to immediately place any ne interventions to care plan and communicate to staff. DON to do we	ILY D D ED Z B,C ARD: oted ill d sis sw	
	chair before R1 fell returned to the faci	I R1 to guide her back into the NA-A stated since R1 had lity, the staff had rearranged he bed against the wall and			communicate to staff. DON to do we audit that al-root-cause analysis hudo were performed in a timely manner for every fall within the facility.	dles	
	were placing pillow to ensure R1 did no stated R1 was quic she was unable to	s underneath the bed sheets ot crawl out of the bed. NA-A k and did not remember that ambulate on her own.			At quarterly QAPI meeting, continue t discuss all falls within facility noting a trends in times and/or places. Will no add new agenda topic to discuss	iny	
	assist R1 to bed. F be against the wall	and NA-D were observed to R1's bed was not observed to . NA-A stated the room had second time to ensure a			residents with high-risk for falls and residents with repeated falls in more to gather input from all disciplines.	detail	

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		& MEDICAID SERVICES	()(0)	TIE: -			0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (COMF	SURVEY PLETED
		245251	B. WING			01/2) 23/2019
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	RSING HOME			23 SOUTH MINNESOTA ROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETIO DATE
F 689	• · · · · · · · · · · · · · · · · · · ·		F 6	89			
	was transferred from extensive assistance positioned in a low mattress with a air	as able to fit in the room. R1 m the recliner to the bed with ce of one staff. R1 was bed, equipped with a concave mattress overlay inside of the			Revise the facility Leader Evaluation Module (LEM), goal for further moni- by senior leaders to reduce falls rate within the facility.	toring e	
	were positioned on pressure pad alarm buttocks/lower back under the bed shee of the bed. R1 was	per family request), fall mats either side on the bed, a silent was positioned under R1's and pillows were positioned to prevent R1 from rolling out observed to be calm and			Seek direction of Pharmacist, Prima Care Provider and/or Medical Direct appropriate for any concerns with poinfection, medication interactions, ar clinical oversight, and other care are identified.	or as ossible nd	
		stated she had been working fall on 1/6/19. RN-A stated R1			RiverView Care Center ATTACHMENT A:		
	stood up independe was supposed to ha	ing room chair when she ently and fell. RN-B stated R1 ave one to one supervision een anxious earlier in the day.			SUBJECT: Care Plan, Comprehe Interim, Short Term	nsive,	
	RN-B confirmed R1 when she fell. RN- falls and R1's fall in her with diversional mats next to the be needed or offer sna injury at the time of emergency room.	I was alone in the dining room B stated R1 had a history of terventions included providing activities, a bed alarm, fall d, assist with toileting as acks. R1 was assessed for the fall and was sent to the RN-B confirmed at the time of he dining room without 1:1			POLICY: Each resident will have comprehensive plan of care develop later than 7 days after the completio the comprehensive assessment (21 from admission) by the interdisciplin team. The comprehensive care plan evaluated and revised as necessary reflect the resident s current status required by law and regulation.	oed no n of days ary n is r to	
	-At 7:13 p.m. FM-A FM-A stated in the sustained different FM-A felt the facility care for the resider companion had bee	was interviewed via phone. past two weeks, R1 had fractures because of falls. / had enough staff to provide its, however, a personal en privately hired to provide a onal supervision (24 hours a			INTERDISCIPLINARY TEAM: Include but not limited to: the resident where possible, resident □s legal guardian chosen representative, attending physician, a registered nurse, social worker, activity, dietary, nursing rehabilitation, direct care givers (RN CNA).	e or	

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		& MEDICAID SERVICES				MB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		E SURVEY PLETED
			/				С
		245251	B. WING			01/2	23/2019
IAME OF F	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	SING HOME			23 SOUTH MINNESOTA ROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 689	Continued From pa	ge 8	F 6	89			
	-At 7:23 p.m. NA-D room at all times ar prevention. NA-D s and currently had a On 1/23/19, from 7: continuously observ- At 7:16 a.m. R1 wa back in a low bed, e either side of the be concave mattress w pillows were position right side. R1 was -At 7:42 a.m. NA-A R1 from the bed to observed to express On 1/23/19, at 7:55 assessment was to duty at the time of the oncoming RN if the at the time of the far record and confirment not completed after further interventions RN-A stated upon F no new fall intervent was determined R1 significant change I returning. RN-A ex	stated R1 was to stay in her nd was to be monitored for fall tated R1 had a history of falls broken pelvis. 15 a.m. to 10:00 a.m. R1 was ved. as observed resting on her equipped with fall mats on ed, a silent personal alarm, with air mattress overlay, and ned under the sheet on the			 (Interdepartmental) plan of care with Be developed by using the ind resident assessment data and the resident assessment data and the resident sequence. Have a problem or strength stat that is resident-focused and related care plan sequence. List realistic and measurable grelated to the problem or strength statement and have timetables to a long-term and short-term goals. Intervention/approaches should developed to help residents in measidentified resident-focused goals. Identify qualified individuals to implement identified interventions/approaches. Identify Resident Susceptibility Abuse by placing an * by the area assessed as making them Susceptabuse. Be reviewed a minimum of ever days. Be reviewed with the resident, resident s legal guardian or chose representative. Social Services will invited to the scheduled care conference. 	ividual omary atement d to the joals meet d be eting v to tible to ery 90 en l be erence. tes will	
	change assessmer R1's care plan had fall. Upon review o RN-A stated she wa	updated after the significant at was done. RN-A confirmed not been updated since the f the CT scan dated 1/12/19, as unaware of the newly r T11 fractures as identified on			to the attention of care center staff report, huddle, communication boo nursing assistant care sheets. MEMORY CARE: In addition to the above, the Resid Plan of Care must include: 1. A statement of the behavioral of	ok and ent	

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						MB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245251	B. WING			C 01/23/2019
NAME OF I	PROVIDER OR SUPPLIER		-		TREET ADDRESS, CITY, STATE, ZIP CODE	01/23/2019
					23 SOUTH MINNESOTA	
RIVERVI	EW HOSPITAL & NUP	RSING HOME			ROOKSTON, MN 56716	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETI
F 689	Continued From no		E O	~~		
F 009	- 1	-	F 68	89		
		stated R1 had a long history s to have fall interventions in			their causes, and the goals to be	
		he could not recall any			accomplished. 2. The treatment plans will be dea	signed
		ll plan between 1/4/19-1/6/19.			to correct or compensate for the	Signed
		aff members are accustomed			behavioral problems.	
		room as they walk by in the			3. Guardians and family member	s will
		o not document each time they			be consulted when developing the	
	go by.				care.	•
					Care Plan Focus	
		ON stated R1 sustained a fall			1. Delirium	
		ractures on 1/6/19, however,			2. Cognitive Loss	
		e compression fractures at L1,			3. Sensory (Hearing, Vision)	
		ed on the 1/12/19, CT scan.			4. Communication	
		d R1 was impulsive and supervision as identified			 ADL Functional Rehabilitation 	
		ecertification survey and as			7. Toileting (continence, incontine	nce
		12/19, five day investigation			diarrhea, constipation)	,100,
		he State Agency. The DON			8. Psychosocial well-being	
		ty had not completed a			9. Mood State	
		alysis of the fall sustained on			10. Behavioral Symptoms	
		interventions to minimize falls			11. Activities	
	were not implemen	ited and R1 sustained an			12. Falls	
		12/19, which resulted in			13. Nutritional Status	
	additional fractures	5.			14. Potential for Choking	
	The sum data d Call D				15. Feeding tubes	
		Prevention Program policy ould evaluate the present use			 Dehydration/Fluid Maintenance Oral/Dental Care 	9
		terventions as to whether or			18. Pressure Ulcers Skin	
		ig the resident safe from falls.			19. Psychotropic Drug Use	
		fallen despite fall prevention			20. Physical Restraints	
		n place, the RN would identify			21. Pain	
		ient further protocols.			22. Diagnosis-Related	
		·			23. Potential for Abuse	
		(Post-Fall Review) policy			24. Self-Preservation	
		working at the time of the fall			25. Advanced Directives	
		nation and chart accordingly			26. End of Life	
		r interventions as deemed			27. Discharge plan	
		prehensive post fall			INTERIM CARE PLANS:	
	observation was to	be completed within 24 hours.			 An interim care plan will be sta 	rted on

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						<u>1B NO.</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION (E SURVEY PLETED
			A. DOILDII				2
		245251	B. WING				23/2019
NAME OF F	PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	-	
RIVERVI	EW HOSPITAL & NUF	RSING HOME			23 SOUTH MINNESOTA		
				С	ROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIOI DATE
F 689	Continued From pa	age 10	F 68	89			
	· ·	icated all falls would be	1.00	00	admission/re-admission and when a		
		DT meeting to assure proper			significant change assessment is ini		
	interventions in pla	ce.			2. The Interim Care plan will be file	ed in	
					the resident overflow chart upon		
		mprehensive, Interim, Short 12/8/05, indicated each			completion of the Comprehensive Pl Care.	ian of	
		/e a comprehensive plan of			Cale.		
		owing a comprehensive					
		care plan was to be evaluated					
		essary to reflect the resident			RiverView Care Center		
		equired by law and regulation. Ected the staff to implement			ATTACHMENT B:		
		and short term care plans as			AT MORIMENT B.		
	needed.	•			SUBJECT: Fall Prevention Program	ı	
	On 1/23/10 at 2.50) p.m. the DON reviewed the			POLICY: To implement and use a fa	all	
		d confirmed the facility was not			prevention and reduction program to		
		izing short term care plans or			provide prompt treatment and preve		
		o the care plans as needed.			further injury.		
		e RN that had been in charge					
		ns was no longer working at ad been missed by the other			INTERNAL CARE CENTER PRACT All residents admitted to the Care Ce		
	staff members.	d been missed by the other			pose a risk for falls and require all st		
					be observant and proactive in meetin		
		dministrator and DON were			their needs.		
		equent attempts to self					
		pervision, history of falls es, lack of comprehensive			PROCEDURE: This program include is not limited to the following process		
		falls along with implementation			is not infined to the following process	303.	
		minimize falls which resulted in			1. The fall risk assessment: a form	n used	
	IJ for R1.				to assess a residence risk level for		
	The immediate iss	pardy that bacan an 1/6/10			potential Falls which is completed at	the	
		pardy that began on 1/6/19, /24/19, at 3:35 p.m. but			time of the admission and quarterly thereafter.		
		be and severity level G - actual			2. Event report: an internal form is	used	
		lity implemented a removal			to report all necessary information		
	plan which was ver	ified by the staff included the			regarding a fall or incident. This form		
	following:				completed by the LPN or RN as soo		
					possible following a fall or incident. T	INIS	

Facility ID: 00470

	-	I AND HUMAN SERVICES			OMB NO.	APPROVEI 0938-039
TATEMENT	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245251	B. WING			C 23/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		
RIVERVI	EW HOSPITAL & NUP	RSING HOME		323 SOUTH MINNESOTA CROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETIO DATE
F 689	Continued From pa	age 11	F 68	39		
	-Completed a comp R1. -Updated R1's care how monitor R1 wh -Updated and imple procedure regardin interventions follow revision. -Staff members we R1's plan of care a prevention policy. R3's Diagnoses Re R1 had diagnoses Parkinson's diseas R3's quarterly MDS was alert and orien transfers, ambulation	prehensive fall assessment for e plan to direct the staff as to hen agitated. emented policies and bg falls. Immediate ring a fall and care plan ere educated on the changes to nd revisions to the fall eport dated 1/23/19, indicated which included dementia and		 form is completed on the system Matrix. 3. RN post-fall assession post-fall assession post-fall assessment is by an RN within 24 houre This should include idere protocols in place and we different interventions the implemented. 4. Fall prevention protection with the RN assessment. IDT will control analysis daily on each find place within the facility I Friday. On weekends, F falls for any immediate cause and pass off to II Monday. 	ment observation: to be completed rs of the incident. ntified risk factors, what new or nat were ocols: a form us fall prevention used in l post-fall omplete root cause all that has taken Monday through RN to review all interventions/root	
	R3's Annual MDS of alert, orientated and and activities of dai R3 did not have a h R3 did not require a annual MDS. R3's Care Plan dat at risk for falls relat walker. The care p -Give verbal remino without walker or if times without it. -Keep call light in re	dated 6/3/18, indicated R3 d independent with ambulation ily living. The MDS indicated history of falls. a Falls CAA at the time of the ed 7/27/17, indicated R3 was red to utilizing a wheeled blan interventions included: ders not to ambulate/transfer feeling dizzy. Will walk at		Fall Risk Assessment Fall risk assessments n for each resident within admission (no later thar quarterly and with a sign condition. Residents with 10 or greater are consid for falls and will have fal interventions initiated 1. Process a. The admitting RN s complete the fall risk as within 4-6 hours of adm from hospital (no later the b. A total score of 10 of considered high risk for shall result in the implet prevention protocols.	4-6 hours of 1 24 hours), nificant change in th a total score of dered to be at risk Il prevention hall accurately sessment form ission or return han 24 hours). or greater is to be potential falls and	

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		<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	· ·		COMPLETED
					С
		245251	B. WING		01/23/2019
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE
RIVERVI	EW HOSPITAL & NUF	RSING HOME		323 SOUTH MINNESOTA CROOKSTON, MN 56716	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE COMPLETIO HE APPROPRIATE DATE
F 689	Continued From pa	ige 12	F 68	39	
	toning, positioning, mobility devices. -Provide an environ During the survey of 4:00 p.m. to 8:00 p. - 4:00 p.m. and on 4:00 p.m. R3 was of independently in he devices. While am was observed to ut R3's gait was stead observed. A Safety Events - F a.m. indicated R3 h staff while observin suddenly fell backw head on the floor. The report indicated were being followed and no further inter The Post Fall Assessindicated R3 had be assessment indicated added to monitor R dizziness. Review of R3's card direction for the staf feelings of dizziness On 1/23/19, at 12:3 the ability to ambula	transfer training, gait graining, ment free of clutter. conducted on 1/22/19, from .m., on 1/23/19, from 7:00 a.m 1/24/19, from 8:00 a.m. to observed to ambulate er room without assistive bulating in the hallway, R3 ilize a front wheeled walker. By and no impairments were fall report dated 1/9/19, at 9:30 had been standing near two g an activity when R3 vards onto her back and hit her R3 did not sustain an injury. d all care plan interventions d and to were to be continued ventions were required. ssment completed on 1/9/19, een sustained a fall. The ted a new intervention was i3's gait and any feelings of e plan lacked description or ff to monitor R3's gait or		 c. The quarterly, signific annual fall risk assessme responsibility of the RN. d. The RN or LPN and w for fall prevention interver update the residents care Fall Event The fall event report is us necessary information reg- incident. This form is com LPN or RN as soon as po- a fall or incident. This forr on the computer system of The fall event report cont information regarding the condition prior to and after incident it is the LPN or R to evaluate the resident to additional care is needed goal is to make sure the r the care and services need fall or incident. The family and MD must incidents accidents or fall services designee, Direct and administrator will be incidents, accidents or Fall serious injury. RN post-fall assessment A registered nurse must of fall observation following 	ents will be the will document all ntions and e plan as needed. ed to report all garding a fall or npleted by the possible following m is completed matrix. ains vital resident er a fall or N's responsibility o determine if . The ultimate resident obtains eded following a be notified of all . The social or of Nursing notified of alls resulting in observation complete a post
	- At 1:20 p.m. the D	OON confirmed R3 had the		incident preferably on the occurred or within 24 hou	

Facility ID: 00470

		AND HUMAN SERVICES				FO	ED: 02/19/2019 RM APPROVED IO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·				OATE SURVEY
		245251	B. WING	3			C 01/23/2019
NAME OF F	PROVIDER OR SUPPLIER		_		STREET ADDRESS, CITY, STATE, ZIP (51/25/2019
RIVERVI	EW HOSPITAL & NUF	RSING HOME		-	323 SOUTH MINNESOTA CROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 689	the Post Fall asses to monitor R3's gait dizziness. The DO identified new inter- new interventions h plan. The DON con	on her own. She confirmed sment included interventions t and to monitor feelings of N confirmed the staff had ventions for R3, however, the had not been added to the care nfirmed the facility failed to to ensure continued care	F	689	 Process The RN must fill out the completely as possible accorresponder questions on the b. The RN will evaluate the of fall prevention intervention whether or not they're keep resident safe from falls. If the resident has falled prevention protocols alread RN will identify the need to further protocols. (See Fall Protocols for ideas). Put all intervention protocols alread communicate new intervent center team via report, hud assistant care sheets and or book. Fall Prevention protocols/in implemented to prevent a senvironment for all resident spotential to self-transfer, the to have their mobility device at all times when not in dire of staff. 	ording to the computer. he present us ons as to bing the n despite fall ly in place, th implement Prevention cocols for the are plan to iately and tions to care dle, nursing communications terventions as afe ts. When a at risk for a fa erventions w tant to s that have th ey are requir e within react act supervision	e on re III, III e ed n
	67(02-99) Previous Versions	Obsolete Event ID: VVD81	_		Fall prevention protocols/in		eet Page 14 of 25

Facility ID: 00470

If continuation sheet Page 14 of 25

		AND HUMAN SERVICES				FORM	02/19/2019 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				СОМ	E SURVEY PLETED
		245251	B. WING	;			C 23/2019
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	RSING HOME			23 SOUTH MINNESOTA CROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 14	F	689	may include but are not limited to Vital signs and neurological of laboratory testing or monitoring therapeutic drug levels as applicat BIMS to determine change in status Sleep study Diversional Activities Bed at resident knee height if ambulate Bed low to floor if requires Ho je Bed rail to aid in transfers Use of anti-roll back device Assistive device within reach times Exercise maintenance progra Use of mats if requires Hoyer Alteration of room arrangeme Toileting/walking programs Use of transfer belt on contin when up in chair when the risk of from sudden attempts to stand ar present. Additional interventions to consid of fall with high-risk falls patients history of falls include: 1) Immedi review of medications by pharma Primary care provider consult. 3)I director consult to review possible oversite with chart review. 4) PT/f evaluation. RiverView Care Center RiverView Care Center	hecks ng of ble mental f able to over at all am ent uous falls re er at time with ate cist. 2) Medical e clinical	

Facility ID: 00470

		AND HUMAN SERVICES				FORM	02/19/2019 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	Сом	E SURVEY PLETED
		245251	B. WING	;			C 23/2019
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	RSING HOME			23 SOUTH MINNESOTA ROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 689	Continued From pa	ıge 15	F	689	 SUBJECT: Fall Prevention Pro POLICY: To implement and use prevention and reduction progra provide prompt treatment and p further injury. INTERNAL CARE CENTER PR All residents admitted to the Ca pose a risk for falls and require be observant and proactive in m their needs. PROCEDURE: This program in is not limited to the following pro 1. The fall risk assessment: a to assess a residence risk level potential Falls which is complete time of the admission and quart thereafter. 2. Event report: an internal for to report all necessary informati regarding a fall or incident. This completed by the LPN or RN as possible following a fall or incide form is completed on the compo- system Matrix. 3. RN post-fall assessment ob post-fall assessment is to be co by an RN within 24 hours of the This should include identified ris protocols in place and what new different interventions that were implemented. 4. Fall prevention protocols: a which presents numerous fall pr intervention ideas to be used in conjunction with the RN post-fall 	a fall m to revent ACTICE: re Center all staff to eeting cludes but cesses. form used for ed at the erly m is used on form is soon as ent. This iter servation: mpleted incident. k factors, or	

Event ID: VVD811

Facility ID: 00470

If continuation sheet Page 16 of 25

		AND HUMAN SERVICES				FORM	02/19/2019 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245251	B. WING				_ 23/2019
NAME OF	PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 01/2	
RIVERVI	EW HOSPITAL & NUR	RSING HOME			23 SOUTH MINNESOTA ROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	Continued From pa	ıge 16	F	589	assessment. IDT will complete roc analysis daily on each fall that has place within the facility Monday thr Friday. On weekends, RN to review falls for any immediate interventior cause and pass off to IDT team for Monday. Fall Risk Assessment Fall risk assessments must be cor for each resident within 4-6 hours admission (no later than 24 hours) quarterly and with a significant cha condition. Residents with a total so 10 or greater are considered to be for falls and will have fall prevention interventions initiated 1. Process a. The admitting RN shall accurate complete the fall risk assessment within 4-6 hours of admission or re- from hospital (no later than 24 hours) b. A total score of 10 or greater is considered high risk for potential fa- shall result in the implementation of prevention protocols. c. The quarterly, significant chan annual fall risk assessments will bo responsibility of the RN. d. The RN or LPN and will docum for fall prevention interventions and update the residents care plan as Fall Event The fall event report is used to rep necessary information regarding a incident. This form is completed by LPN or RN as soon as possible for	taken ough w all ns/root r review npleted of , inge in core of at risk n tely form turn rs). s to be alls and of fall ge and e the needed. ort all fall or / the	

Facility ID: 00470

		AND HUMAN SERVICES				FORM	02/19/2019 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				`´CO№	E SURVEY IPLETED
		245251	B. WING	3			C 23/2019
NAME OF I	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		23/2013
RIVERVI	EW HOSPITAL & NUF	RSING HOME			23 SOUTH MINNESOTA CROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 689	Continued From par	ıge 17	F	689	a fall or incident. This form is co on the computer system matrix. The fall event report contains vit information regarding the reside condition prior to and after a fall incident it is the LPN or RN's res to evaluate the resident to deter additional care is needed. The u goal is to make sure the residen the care and services needed for fall or incident. The family and MD must be notif incidents accidents or fall. The s services designee, Director of N and administrator will be notified incidents, accidents or Falls rest serious injury. RN post-fall assessment observ A registered nurse must comple fall observation following a resid incident preferably on the shift th occurred or within 24 hours. 1. Process a. The RN must fill out the form completely as possible accordin prompter questions on the comp b. The RN will evaluate the pre- of fall prevention interventions a whether or not they're keeping th resident safe from falls. c. If the resident has fallen des prevention protocols already in p RN will identify the need to imple further protocols. (See Fall Prev	al nt or ponsibility nine if ltimate t obtains llowing a fied of all ocial ursing of ulting in ation te a post ent fall or te fall n as g to the uter. sent use s to he pite fall lace, the ement	

Event ID: VVD811

Facility ID: 00470

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		AND HUMAN SERVICES				FORM	02/19/2019 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	Сом	E SURVEY PLETED
		245251	B. WING	G			C 23/2019
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CO		20/2013
RIVERVI	EW HOSPITAL & NUF	RSING HOME			23 SOUTH MINNESOTA ROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	Continued From pa	ıge 18	F	689	 Protocols for ideas). d. Put all intervention protocolindividual resident on the caraprevent further falls immediate communicate new intervention center team via report, huddle assistant care sheets and colibook. Fall Prevention Protocols/Interimplemented to prevent a safe environment for all residents. resident is identified to be at fall prevention protocols/interibe implemented. It is importaremember that all residents the potential to self-transfer, they to have their mobility device vat all times when not in direct of staff. Fall prevention protocols/interimation protocols	e plan to tely and ons to care e, nursing mmunication erventions rventions are fe . When a risk for a fall, ventions will int to hat have the vare required within reach t supervision rventions ed to: cal checks itoring of plicable ge in mental ght if able to as Hoyer	

Facility ID: 00470

		AND HUMAN SERVICES & MEDICAID SERVICES			FC	RM	02/19/2019 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY PLETED
		245251	B. WING			(01/2	23/2019
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
RIVERV	EW HOSPITAL & NUF	RSING HOME			23 SOUTH MINNESOTA ROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 689 F 712 SS=D	Physician Visits-Fre CFR(s): 483.30(c)(§483.30(c) Frequer §483.30(c)(1) The r physician at least o 90 days after admis 60 thereafter. §483.30(c)(2) A phy timely if it occurs no date the visit was re §483.30(c)(3) Exce (c)(4) and (f) of this visits must be made §483.30(c)(4) At the	equency/Timeliness/Alt NPP 1)-(4) ncy of physician visits residents must be seen by a nce every 30 days for the first asion, and at least once every ysician visit is considered of later than 10 days after the	F 6		 Use of anti-roll back device Assistive device within reach at all times Exercise maintenance program Use of mats if requires Hoyer Alteration of room arrangement Toileting/walking programs Use of transfer belt on continuous when up in chair when the risk of falls from sudden attempts to stand are present. Additional interventions to consider at to of fall with high-risk falls patients with history of falls include: 1) Immediate review of medications by pharmacist. 2 Primary care provider consult. 3)Medic director consult to review possible clinit oversite with chart review. 4) PT/OT evaluation.) al cal	2/18/19

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		AND HUMAN SERVICES				APPROVE 0938-039
TATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245251	B. WING _			C 23/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	RSING HOME		323 SOUTH MINNESOTA CROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 712	and visits by a physical control of the second and	bersonal visits by the physician sician assistant, nurse cal nurse specialist in aragraph (e) of this section. NT is not met as evidenced w and document review, the ure newly admitted residents ysican visits for the first ninety dents (R4) reviewed for 30 day addition, the facility failed to esidents received routine ery 60 days) for 1 of 3 ewed for routine physican care.	F 71	2 The facility Policy of Physician vi been updated to replace current of "periodic" being replaced by "T physician visit must be conducted the first 30 days of admission, an 30 day intervals up until 90 days admission date, After the first 90 visits must be conducted at least every 60 days thereafter." Resid for Physician visits will be review weekly IDT, (Inter-disciplinary me to ensure timely compliance with regulation. This will include all res the Care Center, including reside and R5. Residents R4 and R5 w their physician visit completed by 02/18/2019. PERFORMANCE WILL BE MON FOR ALL RESIDENTS, BY REVI RESIDENTS PHYSICAN VISIT ID DATES,(INCLUSIVE OF R4 AND R5),FOR PHYSICIAN VISITS DL WITHIN 30 DAYS. THESE REV WILL BE CONDUCTED DURING WEEKLY INTER-DISCIPLINARY MEETINGS. MONITORING WIL DONE THROUGH KEEPING TR RESIDENTS THAT ARE DUE W DAYS IN THE NURSES PLANNE BOOK AT THE NURSES STATIC RESIDENTS WILL HAVE THEIR PHYSICIANS OFFICE CONTAC WITHIN 2 WEEKS IN ADVANCE	anguage he first d within d than at after the days, once ents due ed during betings), this sidents of nts R4 ill have ITORED EWING DUE IE EWS TEAM L BE ACK OF ITHIN 30 ER N.	

Facility ID: 00470

	OF DEFICIENCIES F CORRECTION	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	<u>0938-039</u> E SURVEY IPLETED
ID PLAN U	FCORRECTION	IDENTIFICATION NOMBER:	A. BUILDIN	IG		C
		245251	B. WING			23/2019
IAME OF F	PROVIDER OR SUPPLIER		· [STREET ADDRESS, CITY, STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	RSING HOME		323 SOUTH MINNESOTA CROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 712	Continued From pa	ige 21	F 71	2		
	examined R5 on 12 3/3/2018. R5's recorreceived routine 60 On 1/24/19, at 11:0 had not received ro directed. The DON nurse had kept trace visit each resident, left the facility, som missed. The Facility Admiss Acceptance of Res- indicated residents by a physican perio	2/16/18, 9/26/18, 6/23/18 and ord lacked indicated R5 had day visits. 0 a.m. the DON confirmed R5 putine physican visits as I stated a former registered of when the physican was to however, when the RN had e of the routine visits were sion: Application and ident policy dated 5/1998, were to agree to be examined odically at intervals not to		DATE DUE, AS A REMINDER TO ENSURE PROPER COMPLIANO DIRECTOR OF NURSING, OR DESIGNATED NURSE ON STAF ESTABLISH CONTACT WITH TH PHYSICAN'S OFFICE TO REMII THEM OF THE DEADLINE TO B AUDITS WILL BE PERFORMED MONTHLY FOR COMPLIANCE A REVIEWED DURING QUARTER MEETINGS WITH THE MEDICA DIRECTOR IN ATTENDANCE. The update to the Physician visits was completed on 02/13/2019.	CE. THE F, WILL HE ND E MET. AND RLY QAPI L	
F 838 SS=F	On 1/24/19, at 12:3 administrator stated was the only policy visits, however, he direct the staff as to were to be examine Facility Assessmen CFR(s): 483.70(e)(§483.70(e) Facility The facility must co	d the facility admission policy that addressed physican confirmed the policy did not p how frequently the residents ed by a physican. t 1)-(3) assessment. onduct and document a	F 83	8		2/23/19
	resources are nece competently during and emergencies. update that assess least annually. The update this assess facility plans for, an	ment to determine what essary to care for its residents both day-to-day operations The facility must review and ment, as necessary, and at facility must also review and ment whenever there is, or the by change that would require a ation to any part of this				

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					FORM	02/19/2019 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1)	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED C
	245251	B. WING				23/2019
NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RIVERVIEW HOSPITAL & NURSING	GHOME			23 SOUTH MINNESOTA ROOKSTON, MN 56716		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 838 Continued From page 2 assessment. The facility address or include: §483.70(e)(1) The faciliti including, but not limited (i) Both the number of re- resident capacity; (ii) The care required by considering the types of physical and cognitive d and other pertinent facts that population; (iii) The staff competence provide the level and typ resident population; (iv) The physical enviror services, and other physical that are necessary to car (v) Any ethnic, cultural, or may potentially affect the facility, including, but no food and nutrition service §483.70(e)(2) The faciliti but not limited to, (i) All buildings and/or or and vehicles; (ii) Equipment (medical (iii) Services provided, s pharmacy, and specific (iv) All personnel, includ employees and those w contract), and volunteer education and/or trainin- related to resident care; (v) Contracts, memoran or other agreements wit	22 ty assessment must ity's resident population, d to, residents and the facility's y the resident population of diseases, conditions, disabilities, overall acuity, ts that are present within rcies that are necessary to opes of care needed for the onment, equipment, visical plant considerations are for this population; and or religious factors that he care provided by the ot limited to, activities and ces. ity's resources, including other physical structures I and non- medical); such as physical therapy, e rehabilitation therapies; ding managers, staff (both who provide services under rs, as well as their ng and any competencies	F 8	338			

Facility ID: 00470

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ·	IPLE CONSTRUCTION		E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		
		245251	B. WING _			C 23/2019
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		20/2010
RIVERVI	EW HOSPITAL & NUI	RSING HOME		323 SOUTH MINNESOTA CROOKSTON, MN 56716		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 838	Continued From pa	age 23	F 83	38		
	(vi) Health information such as systems for	and emergencies; and tion technology resources, or electronically managing d electronically sharing her organizations.				
	all-hazards approa This REQUIREME by: Based on interview facility failed to con assessment of the effective plan was	risk assessment, utilizing an	est	The Facility Assessment has be updated to address and identify process to determine if new or u policies and procedures are nee area of the Facility Assessment updated at least annually, to refl changes needed in procedures t	the pdated ded. This will be ect any	
	conducted on 1/22 jeopardy level define a resident who had the facility's failure assessments follow	of the complaint survey /19 - 124/19, an immediate ciency was identified related to I sustained multiple falls and to conduct comprehensive wing each fall and implement fer to minimize/prevent further		care would be provided accordin policies. Policies will be updated secured in the PolicyTech softwa system. The procedures will be throughout each year with our E Preparedness Committee and th information sharing during week IDT,(Inter-Disciplinary Team), m This Facility Assessment address requirement of determining if ne updated policies and procedures	g to I and Ire reviewed mergency rough y setings. sing the w or	
	revealed the facility develop and implet for the provision of directed the facility determine if new of procedures were n ensure the care pro- in accordance to the	lity Assessment dated 8/2018, had identified the need to ment policies and procedures care. The facility assessment to describe the process to r updated polices and eeded and how they would ovided would be accomplished he facility policies. However, cility Assessment had not been		needed, was updated on 02/14/2		

Facility ID: 00470

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							02/19/2019 APPROVED 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
245251		B. WING			C 01/23/2019			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
RIVERVIEW HOSPITAL & NURSING HOME				323 SOUTH MINNESOTA CROOKSTON, MN 56716				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION S		D BE	(X5) COMPLETION DATE	
	Continued From pa completed. On 1/24/19, at 12:3 reviewed the Facilit the assessment are administrator confir system to ensure th procedures were ro date.	SC IDENTIFYING INFORMATION) age 24 30 p.m. the administrator ty assessment and confirmed ea was blank. The rmed the facility did not have a ne facility policies and butinely reviewed and up to he facility assessment was	TAG		CROSS-REFERENCED TO THE APPRO DEFICIENCY)			

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 8, 2019

Administrator Riverview Hospital & Nursing Home 323 South Minnesota Crookston, MN 56716

Re: State Nursing Home Licensing Orders - Complaint Number H5251019C

Dear Administrator:

A complaint investigation was completed on January 23, 2019. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations 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 licensing 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 violation. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the violation 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 Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing 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 investigator's 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.

When all licensing orders are corrected, the form should be signed and returned electronically to:

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

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request 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.

Sincerely,

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

cc: Licensing and Certification File

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED
		00470	B. WING		01/2	; 3/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DI\/ED\/I	EW HOSPITAL & NUR	SING HOME 323 SOUT		ΑΤΟ		
		CROOKS	TON, MN 56	5716		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated du	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	completed. The cor Correction order iss 4658.0520 Subp. 1	complaint H5251019C was nplaint was substantiated. sued at State Licensing		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for I Homes.	oftware. to	
	-	participate in the electronic				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 02/18/19

Electronically Signed

STATE FORM

6899

If continuation sheet 1 of 18

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	ETED
		00470	B. WING			3/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
RIVFRVI	EW HOSPITAL & NUF	RSING HOME	TH MINNES			
		CROOKS	TON, MN 5	6716		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLE DATE
2 000	Continued From pa	age 1	2 000			
	 Continued From page 1 receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/ obul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health order being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected in the box available for text. You must then indicate in the electronic State licensure process under the heading completion date, the date you orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 			The assigned tag number appe far left column entitled "ID Pref The state statute/rule number a corresponding text of the state s out of compliance is listed in the "Summary Statement of Deficie column and replaces the "To Co portion of the correction order. column also includes the findir are in violation of the state statu statement, "This Rule is not me evidenced by." Following the s findings are the Suggested Met Correction and the Time Period Correction.	ix Tag." nd the statute/rule mcies" omply" This ngs which ite after the t as urveyors hod of For	
D th P co a th th fe as	Department's staff the following correct Please indicate in y correction that you and identify the dat Minnesota Departmenthe State Licensing federal software. Ta	/23/19, a surveyor of this visited the above provider and ction orders are issued. your electronic plan of have reviewed these orders, the when they will be completed. ment of Health is documenting g Correction Orders using ag numbers have been sota state statutes/rules for		THE FOURTH COLUMN WHIC STATES, "PROVIDER'S PLAN CORRECTION." THIS APPLIES FEDERAL DEFICIENCIES ONI WILL APPEAR ON EACH PAG THERE IS NO REQUIREMENT SUBMIT A PLAN OF CORREC VIOLATIONS OF MINNESOTA STATUTES/RULES.	of 3 To .Y. This E. To Tion For	
	column entitled " II statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement	number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute s, "This Rule is not met as wing the surveyors findings				

VVD811

If continuation sheet 2 of 18

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED
		00470	B. WING			23/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF		TH MINNESC TON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 000	• • • • • • • • • • • • • • • • • • • •	Method of Correction and	2 000			
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 830	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 1 Adequate and re; General	2 830			2/18/19
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the ain in bed or the resident n bed.				
	by: Based on observati review, the facility f which resulted in ar the potential for ser impairment to 1 of 3	ent is not met as evidenced ion, interview and document ailed to ensure resident safety n increased risk for falls and rious harm, injury, or 3 residents (R1) reviewed for ified as at risk for falls, had		corrected		

Minnesota Department of Health STATE FORM

6899

VVD811

If continuation sheet 3 of 18

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 01/23/2019				
		00470	B. WING						
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE					
RIVERVIEW HOSPITAL & NURSING HOME 323 SOUTH MINNESOTA CROOKSTON, MN 56716									
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE			
2 830	Continued From pa	age 3	2 830						
	agitation which res attempts. On 1/16/ to self transfer with subsequently fell w fractures and anoth compression fractu and thoracic spine an IJ for R1. In add implement alternati the risk for falls for also identified at ris The immediate jeo p.m. when the staff allowed R1 to be u R1 attempted to se which resulted in p administrator and c notified of the IJ on was removed on 1/ remained at the low isolated, which indi	pardy began on 1/6/19, at 6:15 f identified R1 was agitated yet nattended in the dining room. If transfer and sustained a fall elvic fractures. The director of nursing (DON) were 1/23/19, at 3:18 p.m. The IJ /24/19, but noncompliance wer scope and severity of G - cated actual harm had ntial for more than minimal							
	Findings include:								
	R1 had diagnoses disease, anxiety dis hallucinations, delu	eport dated 1/23/19, indicated which included Alzheimer's sorder, depression, isional disorder, dementia with ince and restless leg							
	10/7/18, indicated I impairment and rec one to two staff for	mum Data Set (MDS) dated R18 had severe cognitive quired extensive assistance of all activities of daily living. cated R1 had experienced one							

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		BERTHIOMICH HOMBER.	A. BUILDING:	A. BUILDING:		
		00470	B. WING			C 23/2019
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	EW HOSPITAL & NUI	RSING HOME	JTH MINNESO			
		CROOK	STON, MN 567			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 4	2 830			
	(bone fracture, join injury with altered of	nd one fall with major injury t dislocation, closed head consciousness, subdural he prior assessment.				
	4/29/18, indicated I antipsychotic and p medications were e experienced falls. falls). R1 used a w assistance of two f wheelchair due to r reminders and cue tried to self transfe falls, usually withou March, resulted in a	ea Assessment (CAA) dated R18 used antidepressant, bain medications. R1's effective but R1 had Fall risk was 22 (high risk for valker and required extensive or ambulation and also used a mobility issues. R1 needed s for wheelchair use and had r a number of times and had ut injury. However, one fall in a compression fracture of the lent bed alarm and a night ligh id by her bed.				
	was at risk for fallin cognition and weak	ised 10/10/18, indicated R1 ng related to dementia, kness and directed staff to owing interventions:				
	-May leave gait bel unexpectedly and s get there. -Give verbal remine without walker. -Keep call light in re	lert staff of movement. t on loosely as gets up starts moving before staff can ders not to ambulate/transfer each at all times. Night light ir				
	training, toning, po training, mobility de -Provide an enviror	erapy (PT) consult for strength sitioning, transfer training, gait				
	information:					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00470	B. WING	B. WING		23/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUR	SING HOME	TH MINNESO TON, MN 567			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ge 5	2 830			
	12:18 p.m. indicated R1 was noted to be and hitting a door w RN-A had directed to the behavior continu 12:25 p.m. indicated family and requested member (FM)-B directed family and requested member (FM)-B directed of the memory carected her. The staff report accommodate FM-I issues." Another PN talked to FM-B on to down. At 3:00 p.m. A Safety Events- Fat dated 1/6/19, at 6:1 on the floor in the d move R1's right leg R1 was transferred evaluation. The Po 1/6/19, fall dated 1// risk for falls and R1 of the fall on 1/6/19 R1's plan to preven sure R1 was escort early. However, th added to R1's care R1's Hospital Disch)/nurse's note dated 1/6/19, at d R1 was agitated and yelling. yelling "I want to go home" ith the palm of her hand. the staff to call R1's family if ued. A subsequent PN at d the staff had called the ed them to visit. Family ected the staff to wheel R1 off e unit in an attempt to calm rted they were unable to B's request due to "staff N at 12:56 p.m. indicated R1 he phone and had calmed FM-A visited R1 at the facility. all report (incident report) 5 p.m. indicated R1 was found ining room. Staff attempted to and she complained of pain. to the hospital for further st Fall Assessment for the 7/19, indicated R1 was at high had been agitated at the time . The assessment indicated t further falls was to make ed out of the dining room is fall intervention was not plan.				
	inferior pubic rami (diagnosed with a ur to return to the nurs bear weight as toler	pelvis) fractures and had been inary tract infection. R1 was sing facility and was allowed to rated, as needed pain rescribed (Percocet), an				
	antianxiety medicat	ion (lorazepam) for agitation the treatment of the urinary				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
00470		00470	B. WING		01/23/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	RSINGHOME	TH MINNESO STON, MN 567			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 6	2 830			
	revealed upon R1's comprehensive fall implementation of i completed following fractures. In additio included revisions f PN dated 1/12/19, a "extremely anxious given as needed pa her recliner. R1 did fall, however, was t room due to facility laboratory levels fro to R1's yellowish (ja admitted to the hos report dated 1/12/1 had slid out of her r have pain but was due to abnormal lal any assessment of Tracking/five day in related to the 1/6/19 facility to the State J indicated R1 had su the facility resulting investigation form in monitoring due to fue standing/walking. I interest when restle record lacked ident cause/unmet need identification of inter risk of further falls. R1's Hospital Disch at 1:23 p.m. indicat gallbladder infection	Diversional activities of her ess." However, R1's clinical				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00470		B. WING			23/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUR	RSING HOME	TH MINNESOT TON, MN 567			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ae 7	2 830			
	surgical candidate a intravenous antibiot pain management v patches. R1 returne hospitalized, a Cat	and was treated with tics while at the hospital. R1's was changed to Fentanyl ed to the facility. While Scan (CT) was performed /ly diagnosed L1, L2 and T11				
	A PN dated 1/16/19, indicated R1 returned to the facility and a personal silent chair alarm was placed in the recliner. R1's care plan was not updated to reflect the new intervention.					
	continuously observing recliner. The recline	00 p.m. to 7:45 p.m. R1 was ved in her room, seated in the er was equipped with a silent personal companion (PC)-A her.				
	stated R1's family h companion to sit wi Shortly there-after,	p.m. registered nurse (RN)-A nad hired the personal th R1 a few hours a day. the DON stated R1's family o stay in her room and they anion.				
	stated R1 had a his on her own. As the when a resident fell for injury, monitored checks if the reside stated R1 had a low and personal silent	ed practical nurse (LPN)-A story of attempting to transfer e charge nurse, LPN-A stated l, she assessed the resident d vital signs and neurological ent had hit their head. LPN-A v bed, fall mats next to the bed alarms on the bed and were to check on R1				
	"frequent" checks. I receive every two h were to document a	r, they did not document the LPN-A stated R1 was to our monitoring and the staff any care provided to R1 every stated the family members had				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURV COMPLETED	
		00470	B. WING			23/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUR	RSING HOME	TH MINNESOT TON, MN 567			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 8	2 830			
	directed the staff to keep R1 in her room.					
	-At 5:50 p.m. nursing assistant (NA)-A was observed to deliver a meal tray to R1's room. PC-A remained with the resident and assisted R1 with the meal.					
	while at the facility a on 1/6/19. NA-A sta room on the evenin escorting other resi when she saw R1 a from a dining room not close enough to chair before R1 fell. returned to the facil her room, placed th were placing pillows to ensure R1 did no stated R1 was quic	stated R1 had sustained falls and had fractured her pelvis ated R1 had been in the dining g of 1/6/19, as NA-A was dents out of the dining room attempt to stand up and fall chair. NA-A stated she was o R1 to guide her back into the . NA-A stated since R1 had lity, the staff had rearranged be bed against the wall and s underneath the bed sheets of crawl out of the bed. NA-A k and did not remember that ambulate on her own.				
	assist R1 to bed. R be against the wall. been rearranged a personal recliner wa was transferred from extensive assistance positioned in a low mattress with a air	and NA-D were observed to R1's bed was not observed to NA-A stated the room had second time to ensure a as able to fit in the room. R1 m the recliner to the bed with be of one staff. R1 was bed, equipped with a concave mattress overlay inside of the per family request), fall mats				
	were positioned on pressure pad alarm buttocks/lower back under the bed shee	either side on the bed, a silent was positioned under R1's and pillows were positioned to prevent R1 from rolling out observed to be calm and				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED		
		00470	B. WING		C 01/23/2019			
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE				
RIVERVIEW HOSPITAL & NURSING HOME 323 SOUTH MINNESOTA CROOKSTON, MN 56716								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE		
2 830	Continued From pa	age 9	2 830					
	was seated in a dir stood up independe was supposed to h because she had b RN-B confirmed R ⁻ when she fell. RN- falls and R1's fall ir her with diversiona mats next to the be needed or offer sna injury at the time of emergency room. the fall, R1 was in t direct supervision.	s fall on 1/6/19. RN-A stated R1 ning room chair when she ently and fell. RN-B stated R1 ave one to one supervision been anxious earlier in the day. 1 was alone in the dining room B stated R1 had a history of nterventions included providing I activities, a bed alarm, fall ed, assist with toileting as acks. R1 was assessed for f the fall and was sent to the RN-B confirmed at the time of the dining room without 1:1						
	FM-A stated in the sustained different FM-A felt the facilit care for the resider companion had be	was interviewed via phone. past two weeks, R1 had fractures because of falls. y had enough staff to provide nts, however, a personal en privately hired to provide a onal supervision (24 hours a						
	room at all times a	e stated R1 was to stay in her nd was to be monitored for fall stated R1 had a history of falls a broken pelvis.						
	continuously obser -At 7:16 a.m. R1 w back in a low bed, either side of the b concave mattress	as observed resting on her equipped with fall mats on ed, a silent personal alarm, with air mattress overlay, and oned under the sheet on the						

STATE FORM

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
ND F LAIN	OF CONNECTION		A. BUILDING:			
		00470	B. WING		C 01/23/2019	
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		323 SOL	TH MINNESO			
IVERVI	EW HOSPITAL & NU	RSING HOME CROOKS	STON, MN 567	716		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	HE APPROPRIATE	COMPLE DATE
			0.000	DEFICIENC	Y)	
2 830	Continued From pa	-	2 830			
	R1 from the bed to the recliner. R1 was not observed to express pain during the transfer.					
	On 1/23/19, at 7:55	5 a.m. RN-A stated a post fall				
		b be completed by the RN on				
		the fall or by the next ere was no RN in the building				
		all. RN-A reviewed R1's clinica	1			
		ed a post fall assessment was				
	•	r the fall on 1/12/19, and no				
		is had been implemented. R1's return from the hospital,				
		ntions were put into place, but i	t			
		1 would have a complete				
		MDS completed 14 days after xplained the significant change				
		npleted on 1/23/19, and the				
	care plan would be	e updated after the significant				
		nt was done. RN-A confirmed				
		I not been updated since the of the CT scan dated 1/12/19,				
		as unaware of the newly				
	diagnosed L1, L2 d	or T11 fractures as identified or	1			
	the CT scan.					
	-At 9:18 a.m. NA-E	stated R1 had a long history				
		is to have fall interventions in				
		he could not recall any Il plan between 1/4/19-1/6/19.				
		aff members are accustomed				
		s room as they walk by in the				
	• •	o not document each time they	/			
	go by.					
	-At 9:20 a.m. the D	ON stated R1 sustained a fall				
		ractures on 1/6/19, however,				
		e compression fractures at L1,				
		ed on the 1/12/19, CT scan. ed R1 was impulsive and				
						1

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00470	B. WING		C 01/23/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUI	RSING HOME	TH MINNESO STON, MN 567			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPL THE APPROPRIATE DAT	
2 830	during the 1/4/19, r indicated on the 1/7 form submitted to t confirmed the facili comprehensive and 1/6/19, alternative if were not implement additional fall on 1/ additional fall on 1/ additional fractures The undated Fall P indicated the RN w of fall prevention in not they are keepin If the resident had protocols already in the need to implem The undated Falls indicated the nurse would gather inform and activate furthen necessary. A composervation was to The policy also ind reviewed at weekly interventions in pla The Care Plan, Co Term policy dated resident was to hav care developed foll assessment. The and revised as neo- current status as re The policy also dire	ecertification survey and as 12/19, five day investigation the State Agency. The DON ity had not completed a alysis of the fall sustained on interventions to minimize falls ted and R1 sustained an 12/19, which resulted in a. Prevention Program policy rould evaluate the present use terventions as to whether or the resident safe from falls. fallen despite fall prevention in place, the RN would identify nent further protocols. (Post-Fall Review) policy working at the time of the fall nation and chart accordingly r interventions as deemed prehensive post fall be completed within 24 hours icated all falls would be (IDT meeting to assure proper				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00470		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
						B. WING
		NAME OF PROVIDER OR SUPPLIER STREET AL			DDRESS, CITY, ST	TATE, ZIP CODE
DI\/ED\/I	EW HOSPITAL & NUI	SING HOME 323 SOL	TH MINNESO	Γ Α		
		CROOK	STON, MN 567	16		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 12	2 830			
	developing and util making revisions to The DON stated th of care plan revisio the facility and it has staff members. -At 3:18 p.m. the an informed of R1's fro transfer, lack of su resulting in fracture assessment of the	d confirmed the facility was no izing short term care plans or o the care plans as needed. e RN that had been in charge ons was no longer working at ad been missed by the other dministrator and DON were equent attempts to self pervision, history of falls es, lack of comprehensive falls along with implementation minimize falls which resulted in	n			
	was removed on 1, remained at a scor harm, after the faci	pardy that began on 1/6/19, /24/19, at 3:35 p.m. but be and severity level G - actual ility implemented a removal rified by the staff included the				
	R1. -Updated R1's care how monitor R1 wh -Updated and imple procedure regardin interventions follow revision. -Staff members we	emented policies and				
		eport dated 1/23/19, indicated which included dementia and e.				

TATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		A. BUILDING:		C		
	00470		B. WING		01/23/2019	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NU	RSING HOME	TH MINNESO STON, MN 567			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 13	2 830			
	was alert and orien transfers, ambulati	S dated 11/2/18, indicated R3 tated and was independent in on and activities of daily living. I R3 did not history of falls.				
	alert, orientated an	dated 6/3/18, indicated R3 d independent with ambulation ily living. The MDS indicated nistory of falls.				
	R3 did not require a annual MDS.	a Falls CAA at the time of the				
	at risk for falls relat	ed 7/27/17, indicated R3 was ted to utilizing a wheeled blan interventions included:				
	without walker or if times without it. -Keep call light in re -Obtain PT consult toning, positioning, mobility devices.	ders not to ambulate/transfer feeling dizzy. Will walk at each at all times. for strengthening training, transfer training, gait graining, nment free of clutter.				
	4:00 p.m. to 8:00 p - 4:00 p.m. and on 4:00 p.m. R3 was of independently in he devices. While am was observed to ut	conducted on 1/22/19, from .m., on 1/23/19, from 7:00 a.m 1/24/19, from 8:00 a.m. to observed to ambulate er room without assistive ibulating in the hallway, R3 illize a front wheeled walker. dy and no impairments were				
	a.m. indicated R3 h staff while observin	all report dated 1/9/19, at 9:30 nad been standing near two ng an activity when R3 vards onto her back and hit he				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
	00470		B. WING			23/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
RIVERVI	EW HOSPITAL & NUF	RSING HOME	JTH MINNESO STON, MN 567			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
2 830	Continued From pa	age 14	2 830			
	head on the floor. The report indicate were being followed	R3 did not sustain an injury. d all care plan interventions d and to were to be continued ventions were required.				
	indicated R3 had b assessment indicat	ssment completed on 1/9/19, een sustained a fall. The ted a new intervention was 3's gait and any feelings of				
		e plan lacked description or aff to monitor R3's gait or s.				
	the ability to ambul	80 p.m. LPN-A stated R3 had ate on her own. LPN-A stated been observing an activity and				
	ability to ambulate the Post Fall asses to monitor R3's gai dizziness. The DO identified new inter new interventions h plan. The DON co	DON confirmed R3 had the on her own. She confirmed asment included interventions t and to monitor feelings of N confirmed the staff had ventions for R3, however, the had not been added to the care nfirmed the facility failed to to ensure continued care ventions.	9			
	The director of nurs all residents at risk receiving the neces prevent/minimize fa designee, could co	THOD OF CORRECTION: sing or designee, could review for falls to assure they are ssary treatment/services to alls. The director of nursing or nduct random audits of the ensure appropriate care and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00470		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SUR COMPLETI		
		B. WING			C 01/23/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
RIVERVII	EW HOSPITAL & NUP	RSING HOME	TH MINNESC STON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 15	2 830			
	services are impler	nented; to minimize falls.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21295	MN Rule 4658.071 and Physician Eval	0 Subp. 3 B Admission Orders uations	21295			2/18/19
	Subp. 3. Frequency of physician evaluations.					
	physician visits mu personally. At the required visits after between personal v visits by a physician practitioner accordi 5600.2670 chapter	ded in this item, all required st be made by the physician option of the physician, the initial visit may alternate visits by the physician and n assistant or nurse ing to parts 5600.2600 to s 6330 and 6340, and s, sections 147.34 and				
	by: Based on interview faciltiy failed to ens received 30 day ph days for 1 of 3 resid physican visits. In ensure long term re physican visits (ever	ent is not met as evidenced and document review, the ure newly admitted residents ysican visits for the first ninety dents (R4) reviewed for 30 day addition, the facility failed to esidents received routine ery 60 days) for 1 of 3 ewed for routine physican care.		corrected		
	R4's Resident Face	e Sheet dated 6/14/18, dmitted to the facility on				

STATE FORM

VVD811

If continuation sheet 16 of 18

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C		
	00470					23/2019
	PROVIDER OR SUPPLIER	323 SOL	DDRESS, CITY, S ⁻ I TH MINNESO T			
RIVERVI	EW HOSPITAL & NUF	RSING HOME	STON, MN 567			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21295	Continued From pa	ige 16	21295			
		oses including dementia with nces and chronic obstructive				
	R4's clinical record indicated R4's physican had examined R4 on 7/18/18, 9/5/18, 11/13/18 and 1/9/19.					
	(DON) confirmed R	00 a.m. the director of nurses 24 had not received every thirty ed for a newly admitted	/			
	indicated R5 was a 12/14/16, with diag	e Sheet dated 12/14/16, dmitted to the facility on nosis including Alzheimer's s, anxiety and major				
	examined R5 on 12	indicated R5's physican had 2/16/18, 9/26/18, 6/23/18 and ord lacked indicated R5 had day visits.				
	had not received ro directed. The DON nurse had kept trac visit each resident,	0 a.m. the DON confirmed R5 putine physican visits as I stated a former registered of when the physican was to however, when the RN had e of the routine visits were				
	Acceptance of Res indicated residents by a physican perio	sion: Application and ident policy dated 5/1998, were to agree to be examined idically at intervals not to mental established minimums.				
monete D	On 1/24/19, at 12: administrator stated epartment of Health	30 p.m. the facility d the facility admission policy				

Minnesota Department of Health								
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL			
00470		B. WING		C 01/23	8/2019			
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE				
RIVERVI	EW HOSPITAL & NUF		TH MINNESO TON, MN 56					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE		
21295	Continued From pa	age 17	21295					
	visits, however, he	that addressed physican confirmed the policy did not b how frequently the residents ad by a physican.						
	The director of nurs all newly admitted r received the approp admission and even director of nursing of random audits to en education to the sta	THOD OF CORRECTION: sing or designee, could review resdients to ensure they had priate physician services upon ry 60 days thereafter. The or designee, could conduct nsure compliance and provide aff. The director of nursing o the quality assurance						
Minnosoto	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one						