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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3HFS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00407

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

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

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

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/12/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **50** (L18)
13.Total Certified Beds **50** (L17)

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date:
Holly Kranz, Unit Supervisor 6/21/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 06/21/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/11/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245395
June 21, 2018

Mr. Scott Kessler, Administrator
Crossroads Care Center
965 McMillan Street
Worthington, MN 56187

Dear Mr. Kessler:

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

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

Effective June 6, 2018 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

Electronically delivered
June 21, 2018

Mr. Scott Kessler, Administrator
Crossroads Care Center
965 McMillan Street
Worthington, MN 56187

RE: Project Number S5395028

Dear Mr. Kessler:

On May 11, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective May 16, 2018. (42 CFR 488.422)

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective July 15, 2018.

This was based on the deficiencies cited by this Department for a standard survey completed on April 26, 2018. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On June 12, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 8, 2018 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 April 26, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 6, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 26, 2018, as of June 6, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective June 6, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of May 11, 2018:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 15, 2018 be rescinded as of June 6, 2018. (42 CFR 488.417 (b))

In our letter of May 11, 2018, we advised you that, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years

from July 15, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on June 6, 2018 the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

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,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3HFS

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Facility ID: 00407

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(L1) **245395**
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(L3) **CROSSROADS CARE CENTER**
(L4) **965 MCMILLAN STREET**
(L5) **WORTHINGTON, MN** (L6) **56187**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/26/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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From (a) :
To (b) :

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date:
Wendy Buckholz, HFE - NE II 05/30/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 06/08/2018 (L20)

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

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

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above:
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22. ORIGINAL DATE OF PARTICIPATION
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 11, 2018

Mr. Scott Kessler, Administrator
Crossroads Care Center
965 McMillan Street
Worthington, MN 56187

RE: Project Number S5395028

Dear Mr. Kessler:

On April 26, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

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

Appeal Rights – the facility rights to appeal imposed remedies; and

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

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

DEPARTMENT CONTACT

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

Holly Kranz, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: holly.kranz@state.mn.us
Phone: (507) 344-2742
Fax: (507) 344-2723

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.12, Freedom from Abuse, Neglect, and Exploitation, 42 CFR 483.24, Quality of Life, or 42 CFR 483.25 Quality of Care; OR
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR
- A facility is classified as a Special Focus Facility (SFF) AND has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective May 16, 2018. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for

imposition:

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 § 488.41(a), effective July 15, 2018.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective July 15, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 15, 2018.

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.

Further, Federal law, as specified in the Act at Sections 1819(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 a denial of payment. Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 15, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, 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.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's 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 revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 15, 2018, the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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

APPEAL RIGHTS

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.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING _____ B. WING _____	04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on April 23rd through April 26th, 2018 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On April 23rd through April 26th, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.	F 558		6/6/18

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

Electronically Signed | 05/20/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING _____ B. WING _____	04/26/2018

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

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F 558	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop interventions to accommodate needs and promote independence with eating for 1 of 1 resident (R9) who had difficulty reaching the table for meals in the dining room. Findings include: R9's quarterly Minimum Data Set (MDS) assessment dated 2/1/18, indicated R9's cognition was moderately impaired, and that the resident required supervision with eating. R9's care plan revised 2/13/18, identified the resident had a terminal prognosis related to moderate protein calorie malnutrition, and was admitted to hospice services on 11/3/17. R9's care plan further indicated to adjust provision of ADLS (activities of daily living) to compensate for resident's changing abilities. On 4/24/18, at 09:07 a.m. R9 was observed eating breakfast in the east dining room. R9 was seated in a wheelchair (w/c) up to a dining room table. The top of R9's chest was level with the table top and the resident had to reach up over her plate to reach the food. R9 was observed to eat sausage links with her fingers. R9 utilized a spoon to eat yogurt having to reach up to spoon it out of the container. R9 spooned up too much yogurt as it was not at a level where she could see into the container; some of the yogurt fell off the spoon onto her chin prior to getting to her mouth. R9 continued having to reach upward to obtain food and fluids throughout the meal.	F 558	F 558 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to ensure reasonable accommodations to all residents. One of the many ways that this has been achieved for resident #9 is by making sure resident has table available at proper height to enjoy meals at a level that meets resident needs. Also, residents reviewed to ensure they are all comfortable at the tables they eat at and able to reach their meals without any struggle. 2.Because all residents stay in our facility and eat in dining room all are potentially affected by the cited deficiency. On 4/25/2018, the DON and ADON walked around and visited with staff and monitored meals to ensure all residents have proper accommodations during meal service. All residents have been determined to be at tables that fit their stature, the 3 ladies that are shorter in height now sit at new table which is adjustable to height to adapt to residents that sit there. No other residents were affected. Quarterly review of residents will	

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	245395	A. BUILDING _____ B. WING _____	04/26/2018

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F 558	Continued From page 2 On 4/24/18, at 3:25 p.m. R9 was observed seated in w/c in the east dining room up to one of the dining room tables. The top of R9's chest was level with the table top. R9 was drinking a glass of grape juice having to reach up to obtain the glass and when setting it back onto the table. On 4/25/18, at 8:47 a.m. R9 was observed seated in w/c eating breakfast in the east dining room. R9 was able to eat independently after staff cut the pancakes into bite size pieces. R9 also had sausage links, scrambled eggs, and an individual container of yogurt on the plate. The table height was level with the top of R9's chest. R9 had to reach up in order to obtain her food and would lean forward and stretch her neck out attempting to see what was on the plate. At 9:04 a.m. the director of nursing (DON) approached surveyor who was seated in a chair across from R9's dining room table. DON handed surveyor forms that had been requested and while talking with surveyor looked over at R9's table. DON then asked the regional director of clinical services, who was also in the dining room, if the dining room table was too high for R9. The regional director agreed that it was. When interviewed at that time the DON agreed the table was too high for the resident. DON further indicated the resident had limitations in her shoulders which with the table height would also make it more difficult for R9 to reach her food. DON confirmed an adaptation to the dining room table was needed in order for R9 to easily access her food and fluids.	F 558	include interdisciplinary review with resident and/or family to ensure reasonable accommodations are being met. 3.To enhance currently compliant operations and under the direction of the DON, on 5/24/2018 all staff will receive in-service training regarding state and federal requirements for reasonable accommodations and review the importance of aiding residents, checking on those that are seen to be spilling or unable to reach their food/fluids and ensuring all residents have access to adequate accommodations to be as independent as possible with meeting their needs. 4.Effective 5/17/2018, a quality-assurance program was implemented under the supervision of the DON to monitor residents to ensure all residents have necessary accomodations for meal service. The DON or designated quality-assurance representative will perform the following systematic changes: audits of dining services to ensure all residents have necessary accommodations for meal services; 5 residents per week x2 weeks and 2 residents per week x 2 months. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented, submitted and monitored at the monthly quality-assurance committee meeting. 5.The DON will be responsible for this	

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F 558	Continued From page 3	F 558	POC. 6.Compliance by June 6, 2018.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report allegations of physical	F 609	F 609 This Plan of Correction constitutes my	6/6/18

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F 609	Continued From page 4 abuse to the State agency (SA) within 2 hours for 1 of 3 residents (R16) who were reviewed for accidents. Findings include: R16's quarterly Minimum Data Set (MDS) dated 2/28/18, identified R16 had severe cognitive impairment and required extensive assistance of two staff with transfers and bed mobility. The MDS further indicated R16 exhibited physical and verbal behavioral symptoms toward others. R16's care plan revised 3/22/18, identified R16 was susceptible to abuse related to cognitive deficit and difficulty making her needs known. Review of R16's incident report dated 4/10/18, at 1:50 p.m. nursing assistants heard a pop in R16's left shoulder when they placed R16's left hand on her walker to transfer. R16 started crying and guarded left arm with right hand. The report further indicated R16 was sent to the emergency room (ER) for x-ray. The nurse progress notes dated 4/10/18, at 2:50 p.m. reported R16 was transferred via ambulance to the emergency room and later (4:20 p.m.) received a call from the ER reporting R16's left humerous had been fractured. R16 returned to the facility around 5:00 p.m. with a sling and ACE wraps wrapped around left arm/shoulder. The initial report to the state agency submitted by the director of nursing (DON) was received 4/11/18, at 1:56 p.m. which was 1 day after the incident. When interviewed on 4/26/18, at 8:45 a.m., the DON verified a report was not made to the state agency within 2 hours. The DON stated she had started to report the incident because R16 had suffered a "significant injury", but wasn't sure which type of allegation to code on initial report. DON further stated she had consulted corporate for guidance, but didn't receive the message until	F 609	written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to report all incidents and do timely follow up on any incident that results in significant injury. In this case R16 was noted to have a fracture obtained during a transfer and reporting did not occur until after 24 hours of incident. In this case, after the surveyor reported the faulty system, the policy and procedure on abuse/neglect and reporting had been reviewed and updated. All staff were in-serviced, and information put at nursing station to ensure process of reporting is followed. Nursing and social service coordinator were also educated on importance of reporting all vulnerable adult cases to the OHFC (office of health facility complaints) within 2 hours for any significant injury – policy is to report then investigate. 2.All residents are potentially affected by the cited deficiency and lack of follow through. A new resident protection manual was created to educate staff on components of the abuse program. The program further educates staff on when to report and what to report to ensure that this type of situation does not occur again. The program also has an incident report guide to assist staff to determine what is	

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F 609	Continued From page 5 the next day on her telephone to report incident right away. The facility Abuse Prevention Program dated 8/1/16, directs a report to the Minnesota Department of Health Office of Health Facility Complaints (OHFC) will be made in accordance with Minnesota Statute 626.557 REPORTING OF MALTREATMENT OF VULNERABLE ADULTS. Report will be submitted by the charge nurse, DON social services director or administrator as soon as possible/practical using the online reporting system.	F 609	reportable and who to notify when. Further discussed was the proper procedure for incident and accidents and the notification process to ensure DON is aware of any situation for immediate follow up. Policy and procedure for abuse/neglect listing content for reportable events was reviewed. No other residents were affected. 3.To enhance currently compliant operations and under the direction of the DON, on 5/24/2018 all staff will receive in-service training regarding requirements for investigating, preventing and correctly handling all incidents and accidents. The guidelines on reporting and OHFC will be reviewed. Incidents will be reviewed daily during the week at stand up with interdisciplinary team. Any deficiencies will be corrected on the spot, documentation reviewed to include follow up nurse's notes, and appropriate notification made to POA, MD, DON, also Administrator and OHFC if appropriate via DON, SSC or Administrator. 4.Effective 5/17/2018, a quality-assurance program was implemented under the supervision of the DON and Administrator to monitor all incidents to ensure anyone with injury or suspected abuse is reported immediately to OHFC. All incidents, accidents and injuries will be reviewed to ensure follow up completed per resident protection manual and investigation log. The DON or designated quality-assurance representative will perform the following systematic changes: the DON in	

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F 609	Continued From page 6	F 609	conjunction with SSC will make report immediately if any abuse/neglect or significant injury was suspected. All incidents/accidents or suspected abuse/neglect situations will be reviewed daily during the week at stand up. The DON or designee will complete audits of all incidents on residents for 8 weeks then 50% of incidents for 8 weeks to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented, submitted and monitored at the monthly quality-assurance committee meeting for further review or corrective action. 5.DON, Administrator and SSC will be responsible for this POC. 6.Compliance by June 6, 2018.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced	F 637		6/6/18

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F 637	Continued From page 7 by: Based on interview and document review, the facility failed to complete a significant change Minimum Data Set (MDS) assessment for a change in functional ability for transfers, ambulation, weight loss, continence and facility acquired stage 2 pressure ulcer for 1 of 2 resident (R28) reviewed for activities of daily living (ADL) decline. Findings include: R28's significant change Minimum Data Set (MDS) assessment dated 1/4/18, identified R28 had moderately impaired cognitive impairment per staff interview and had diagnoses which included Alzheimer's disease and dementia. The MDS identified R28 required supervision (oversight, encouragement or cueing) assistance with ADL's of transfers and walking in corridor on unit, and limited (staff provide non-weight-bearing) assistance for walking in room, and locomotion on and off unit. The MDS revealed R28's weight at the time of the MDS was 160 pounds (lbs). Further the MDS identified R28 was occasionally incontinent of bowel with no pressure ulcers present. R28's quarterly MDS dated 3/29/18, identified R28 had a brief interview for mental status (BIMS) score of 3 indicating severe cognitive impairment. The MDS identified R28 required extensive (staff provide weight-bearing support) assistance with ADL's including transfers,walking in room and corridor, and locomotion on and off unit. The MDS revealed R28's weight at the time of the MDS was 152 lbs. The MDS futher identified R28 was frequently incontinent of bowel and had a stage 2 (partial thickness loss of skin) pressure ulcer. Review of the above assessments indicated an increase need for staff assistance in ADL's of	F 637	F637 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to provide consistent quality care to ensure residents with significant changes are appropriately assessed and necessary interventions put in place and that care plan is accurate. Some of the many ways that this has been achieved for R28 is to formulate an accurate MDS based on resident decline over past few months. In this case, after the survey determined R28 showed a decline in status for needing more assistance with ADL's a significant change was initiated. Assessments done, and care plan developed. 2.Because all residents have constantly changing needs all are potentially affected by the cited deficiency, on 4/25/2018, the MDS nurse reviewed criteria for significant changes with regional team at time of survey. All residents were audited to determine others needing sig change. Other residents determined to have changes have been identified and significant change assessments have been initiated. Policy and procedure on significant change was reviewed and	

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F 637	Continued From page 8 transfers, walking in room and corridor, locomotion on and off unit, a decline in bowel incontinence, an 8 lb weight loss and a newly identified stage 2 pressure ulcer. During interview on 4/26/18, at 7:08 a.m. nursing assistant (NA)-B stated that R28 required extensive assistance with dressing, grooming, toileting, and ambulation. NA-B further stated R28's ADL abilities had declined over the last few months as he had only required supervision for cares previously. During interview on 4/26/18, at 9:15 a.m., registered nurse (RN)-B stated the facility follows the Resident Assessment Instrument (RAI) manual guidelines for completing significant change MDS. RN-B explained the facility had 14 days to determine if changes are self limiting, verify changes in resident ability with NA's, and document these findings in the medical record. Upon review of the R28's significant change MDS dated 1/4/18 and quarterly MDS dated 3/29/18, RN-B verified a significant change MDS should have been completed 3/29/18 due to the decline in R28 ADL's, weight loss, increased bowel incontinence, and newly developed pressure ulcer. The facility policy titled, MDS/CAA dated 3/22/18, indicated a significant change means deterioration in two or more ADL, communication, and/or cognitive abilities that appear to be permanent. The MDS must be completed within 14 days from the date a significant change was recognized. Document the initial identification of a significant change in terms of the resident's clinical status in the progress notes. A significant change in status assessment (SCSA) is not required in a case where the resident's condition is expected to return to baseline within a short period of time, such as one to two weeks. If the	F 637	updated. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 5/24/2018 all nursing staff will receive in-service training regarding changes in resident's condition. The training emphasizes the importance of monitoring ADL's both improvement and decline. 4.Effective 5/17/2018, a quality-assurance program was implemented under the supervision of the DON and MDS Nurse to monitor residents having changes in their care. The MDS nurse or designated quality-assurance representative will perform the following systematic changes: MDS nurse will pull the ADL significant change analysis report and review data to see who has had changes in status and full audit will be done by MDS nurse; 2 audits per week x 4 weeks then 1 audit weekly x 2 months to ensure compliance in this area and initiate sig change if needed. All residents will be reviewed at time of quarterly or annual MDS to ensure not a significant change. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.MDS nurse will be responsible for this POC. 6.Compliance by June 6, 2018.	

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F 637	Continued From page 9 condition does not return to baseline, the assessment should be completed as soon as needed to provide appropriate care to the resident, but in no case later than 14 days after the determination was made that a significant change occurred. An SCSA can be performed at any time after the completion of the admission assessment. If a significant change in status is identified in the process of completing a quarterly assessment, code the assessment as a SCSA and complete a comprehensive assessment. Do not code it as a quarterly assessment.	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to accurately code weight loss on the Minimum Data Set (MDS) for 1 of 3 resident (R14) reviewed for nutrition. Findings include: R14's significant change MDS dated 2/14/18, identified diagnosis including Alzheimer's Disease. The MDS also identified R14's weight for the assessment reference period was 136 pounds and R14 had no or unknown weight loss. Review of the 2/7/18 registered dietician (RD) note identified a last recorded weight of 135.8 pounds on 1/12/18. Review of the recorded weights in the medical record identified a weight	F 641	F641 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to provide accurate assessments on all residents. R14 MDS did not properly indicate weight loss. In this case, after the survey indicated the incorrect information immediately the documentation was reviewed on R14 and dietician made	6/6/18

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F 641	Continued From page 10 of 124 pounds on 2/10/18, and a weight of 146 pounds on 8/4/17. During interview on 4/26/18, at 12:58 p.m. the certified dietary manager (CDM) stated she completes section K (swallowing/nutrition status) of the MDS. The CDM stated well the weights are supposed to pull over into the MDS so I just figured that was the right weight. The CDM verified the weight of 136 pounds identified in the significant change MDS of 2/14/18, was not accurate and the correct weight should have been 124 pounds. She also verified this would have constituted a significant weight loss of over 5% in the last month and over 10% in last 6 months.	F 641	appropriate changes. Assessment completed, and care plan updated. 2.Because all residents receive their level of care based on their assessments all are potentially affected by the cited deficiency, on 5/14/2018, the MDS nurse in conjunction with dietary manager reviewed how information is gathered and importance of doing hands on review with residents to ensure accurate information. In addition, all residents that trigger weight loss have been reviewed and current weights reviewed. All current resident MDS's were reviewed for accuracy and resubmitted when necessary or if determined to need significant change. No other residents were affected. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 5/24/2018 all nursing staff will be in-serviced on training requirements for assessments and MDS/care plans and accuracy of weights. MDS nurse was educated on importance of seeing residents they assess and ensure accuracy. All residents will be reviewed quarterly and annually, and staff interviews will be critical piece in gathering data. All triggers will be care planned and communicated to staff via care sheets if new interventions in place. 4.Effective 5/17/2018, a quality-assurance program was implemented under the supervision of the MDS Nurse in conjunction with nursing and dietary to monitor residents MDS and ensure data	

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F 641	Continued From page 11	F 641	accurate and correct. The MDS nurse or designated quality-assurance representative will perform the following systematic changes: after corrections determined, audit of all MDS's for accuracy will be completed by MDS nurse; 2 audits per week x 4 weeks then 1 audit weekly x 2 months to ensure compliance in this area, including monitoring of weights. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.MDS nurse will be responsible for this POC. 6.Compliance by June 6, 2018.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to communicate and coordinate hospice scheduled cares with facility	F 684	F684 This Plan of Correction constitutes my written allegation of compliance for the	6/6/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 12 staff and failed to develop a care plan for hospice care for 1 of 1 resident (R14) reviewed for hospice services. Findings include: R14 was observed on 4/24/18, at 11:00 a.m. still in bed. Staff stated hospice would be in to get R14 up. Resident was gotten up, out to dayroom and fed breakfast by hospice aide at 11:15 a.m. R14's significant change Minimum Data Set (MDS) dated 2/14/18, identified diagnosis including Alzheimer's disease, moderately impaired cognition and a life expectancy of 6 months or less. Review of R14's medical record identified R14 was started on hospice services on 2/6/18, for primary diagnosis of Alzheimer's Disease with early onset and a secondary diagnosis of debility. R14's facility care plan last revised 4/26/18, did not identify hospice services. The hospice agency plan of care updated 4/10/18, identified hospice aide visits Monday through Friday. The hospice plan of care also identified R14 was unable to provide personal cares independently, was incontinent of bladder and was to receive personal cares daily including skin care, pericare and mouth care. Review of the nursing assistant (NA) visual/bedside kardex report printed 4/26/18, did not identify R14 was receiving hospice services or when and what services would be provided by hospice. R14 was observed on 4/25/18, at 7:30 a.m. to be out to the dayroom for breakfast.	F 684	deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to provide consistent and quality care to all residents and work with ancillary services such as hospice. Some of the many ways that this has been accomplished for R14 is by monitoring hospice services and determining calendar that will be followed for care of residents. If a change in plan regardless of communication, it is expected staff will provide the care of facility residents to ensure they get quality care. Hospice to meet with nurse leadership to ensure services are provided and formulate systematic communication if they will not be available to come to facility that day to ensure staff aware they are to provide all cares. 2.Because many residents have potential for hospice services so many are potentially affected by the cited deficiency, on 5/18/2018, the DON reviewed R14 to ensure staff know cares to be completed and calendar for hospice. All residents receiving hospice services were reviewed and care plans and care sheets updated. No other residents were affected. 3.To enhance currently compliant operations and under the direction of the DON, on 5/24/2018 all nursing staff will	

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F 684	Continued From page 13 R14 was observed on 4/26/18, at 7:30 a.m. to still be in bed. NA-C was asked if they would be getting resident up soon. NA-C stated hospice should be here. They come everyday and get her up. NA-C stated I better check. NA-C went to trained medication assistant (TMA)- A and asked if hospice was coming to get R14 up. TMA-A stated they are not coming in the morning, they aren't going to be here until probably 11ish so you need to go in. NA-C stated we do her cares then? TMA-A stated yes you have to do her cares and get her up as hospice won't be here until later. During interview on 4/26/18, at 9:27 a.m. NA-D stated sometimes we don't know when hospice is coming. They usually come in the morning and get people up. NA-D stated on 4/24/18, hospice wasn't here until 11. That's why no one got her up until then. During interview on 04/26/18, at 2:00 p.m. TMA-A stated she was aware that hospice was coming at 11:00 a.m. this week as "an aide told me." TMA-A stated we have a calendar here somewhere. TMA-A located the calendar in R14's chart. There were no times on the calendar. TMA-A stated I think they call if they aren't coming in the morning I am not sure. During interview on 4/26/18, at 10:52 a.m. the director of nursing (DON) stated the care plan should have been updated to reflect hospice care. The DON also stated hospice shares a schedule with us so staff know when aides are coming or if time changes are made. The DON stated if the schedule changes it should be communicated to the staff on our bulletin board in the computer system. She stated our staff are	F 684	receive in-service training regarding hospice services, reporting absence of hospice staff and necessary guidelines of staff to provide care. Also reviewed importance of documenting when hospice is there or when they are not to track and trend any concerns facility has with hospice services or absence of cares. 4.Effective 5/17/2018, a quality-assurance program was implemented under the supervision of the DON to monitor R14. The DON or designated quality-assurance representative will perform the following systematic changes: audits done on all hospice residents and new admissions with hospice services to ensure continuation of care and communication; 4 residents weekly for 3 months. Any deficiencies will be corrected on the spot, findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.DON will be responsible for this POC. 6.Compliance by June 6, 2018.	

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F 684	Continued From page 14 responsible to go in and provide cares if hospice isn't coming until later. The DON stated she was not sure why the change wasn't communicated to staff.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure interventions were implemented to reduce the fall risk for 3 of 3 residents (R14, R15, R28) reviewed for falls. R14 experienced actual harm when she sustained a hip fracture on 12/26/17, after staff failed to evaluate contributing factors related to repeat falls so that interventions could be developed and/or revised to reduce the risk of injury. Findings include: R14's, admission record dated 4/26/18, indicated R14 was admitted to the facility 7/21/17, with diagnoses including Alzheimer's disease with early onset, generalized anxiety disorder and osteoporosis. R14's significant change Minimum Data Set (MDS) assessment dated 2/14/18, indicated R14 was severely cognitively impaired, had experienced a fall with major injury since the last assessment, required extensive assistance of two	F 689	F689 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to assure residents are free of accident hazards. R14 had multiple falls one fracture r/t fall and no comprehensive assessments were completed no interventions for safety were addressed and this resulted in actual injury. R14 had fall assessment completed, interventions care planned, and care sheets updated. R15 was noted to have had multiple falls with no	6/6/18

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F 689	Continued From page 15 staff with bed mobility, transfers and toileting, and had highly impaired vision. A Care Area Assessment (CAA) dated 2/27/18, indicated R14 had balance problems during transitions and was only able to steady herself with staff assist. The CAA identified R14 had experienced a fall on 1/25/18, with no injuries. The CAA also indicated R14 received psychotropic medications including Trazodone (antidepressant) and Risperdal (antipsychotic) daily, and had received the anti-anxiety medication Ativan, 5 days to the assessment period. R14 was also identified as having difficulty negotiating the environment due to vision problems and an increased risk for falls. R14's risk for falls assessment form dated 2/5/18, indicated R14 had moderate cognitive skills, a fracture related to a fall in the past 6 months, that R14 was chair bound, and legally blind. The risk for falls assessment form did not identify the fall risk score and included no analysis of the assessment. R14's care plan last revised 1/6/18, indicated R14 was at an increased risk for falls related to severe cognitive impairment and vision impairment as R14 was legally blind. In addition, the care plan indicated R14 had no spacial awareness or safety awareness, and had diagnoses including: Alzheimer's Disease, standing balance deficit, slight kyphotic posture, deconditioning related to chronic health condition and impact on ADL's (activities of daily living), incontinence, psychoactive medication use and analgesic use. Care plan interventions included: Be sure the resident's call light is within reach and encourage the family to activate as needed for assistance. Resident typically dose not understand cues, is unable to demonstrate memory skills for activation of call light system to use it for	F 689	determination of root cause nor updated interventions. R28 had multiple falls with no intervention noted. In this case, after the surveyors tagged the building and noted these deficiencies, immediate updates were made on abuse preventions, investigations, incident and accident, and updates for comprehensive assessments completed for all residents that reside in the facility. The policy on incidents and accidents were reviewed. All residents found at risk for falls have had fall risk assessment completed, care plans updated. Staff have been educated on all situations and are aware of necessity follow up and determine root cause with necessary interventions put into place. 2.Because all residents live in this care community where accidents are possible and not always avoidable all are potentially affected by the cited deficiency. All residents that have a fall will have incident report and full investigation completed and reported to DON and state agency as necessary by regulations. All residents that have had falls have been reviewed, assessed and interventions in place and care planned accordingly. No other residents were affected. 3.To enhance currently compliant operations and under the direction of the DON, on 5/24/2018 all staff will receive in-service training regarding state and federal requirements for incidents, accidents, and the need for an environment free of hazards. The training	

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F 689	Continued From page 16 assistance as needed. The resident needs prompt response to al l requests for assistance. (initiated 8/2/17, revised 1/6/18); Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Follow facility fall protocol. The resident needs a safe environment with even floors free from spills and/or clutter; adequate, glare free light; a working and reachable call light, the bed in low position at night; side rails as ordered, handrails on walls, personal items within reach. (initiated 8/2/17, revised 8/2/17). Review of R14's nursing assistant visual/bedside kardex report dated 4/26/18, revealed R14's call light was to be within reach, and that R14's family was to be encouraged to activate the call light as needed for assistance. In addition, the kardex indicated R14 would not typically understand cues, and R14 was unable to demonstrate memory skills for activation of call light system if required for assistance. The kardex indicated the resident required prompt response to all request for assistance, and that staff were to follow the facilty's fall protocol. Review of R14's incident reports revealed the following falls: (1) 9/22/17, 2:41 p.m. Resident attempted to sit in chair in dining room. Misjudged the chair and the chair tipped, R14 hit her head on floor, no injuries observed. The incident report indicated predisposing situation factors as: wanders and ambulates without assistance. In addition, the incident report indicated R14 recieved mostly 1:1 staffing, and received psychotropic and controlled medications. R14 was further identified as impulsive with impaired judgment, impaired safety awareness, was agitated, restless and	F 689	emphasizes the importance of documentation, notification, assessing and care planning, determining root causes and proper interventions to prevent falls. 4.Effective 5/17/2018, a quality-assurance program was implemented under the supervision of the DON and ADON to monitor residents with falls and any incident r/t the environment. The DON or designee will complete audits of falls and those at risk; 4 residents per week x 4 weeks, then 2 residents weekly for 2 months. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting. 5.The Administrator and DON will be responsible for this POC. 6.Compliance by June 6, 2018.	

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demonstrated some aggression. A comprehensive assessment/analysis was lacking to determine whether a revision and/or new interventions were required.
(2) 10/13/17, 8:00 p.m. Resident found on the floor between the bed and wall, no injuries observed. The incident report indicated predisposing situation factors included wandering. A comprehensive assessment was lacking to identify and/or revise current interventions.
(3) 10/14/17, 9:45 p.m. Resident was sitting in recliner resting, attempted to stand and scooted down to opened foot rest tipping recliner forward. Resident slid onto the floor. No injuries observed. Predisposing situation factors indicated R14 was a wanderer. There was no analysis of the fall nor new interventions identified with repeated fall occurrences.
(4) 11/2/17, 7:30 p.m. Resident ambulating without purposeful intent on unit, up and down corridor and in and out of day room which doubles as dining room. Resident observed in day room to be walking around tables, lost balance and fell onto floor, falling onto left side of body. Did not strike her head upon falling. Physical assessment and observations completed. No obvious physical injuries. Assisted to get off floor and seated in recliner to provide resting opportunity. Resident fatigues when walking for prolonged periods, sleep pattern is inadequate at night as well. Fatigue possibly contributing factor in loss of balance, in addition to vision loss and cognitive deficits. No injuries observed. The predisposing factors were identified to include: confused, drowsy, recent change in medications, gait imbalance, impaired memory, ambulating without assistance. There was no analysis and/or fall assessment to

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F 689	Continued From page 18 determine the cause and/or whether new/revised interventions were necessary to maintain resident safety. (5) 11/6/17, 8:12 p.m. CNAs (certified nursing assistants) assisting resident in east shower room/bathroom. Resident in standing position with contact guard assistance of CNAs when resident began to purposefully go from standing to sitting position without warning. Physically supported by CNAs. Resident eased to sitting position as desired. CNA's body used as support and cushion to control position change and maintain gradual transition to sitting by sliding down CNA's leg. Physical exam completed per charge nurse, no apparent injuries noted. Resident assisted with remainder of cares/seated to promote short period of rest. Predisposing factors were identified as: confused, recent change in medications, gait imbalance, impaired memory, and wanderer. The report indicated R14 complained of being "so tired" and seemed unable to rest well. In addition, R14 had a high visual impairment coupled with medication changes, was unfamiliar with staff and circumstance, unfamiliar environment, and labs within acceptable limits. However, there was no comprehensive assessment/analysis of R14's fall nor review of interventions identified. (6) 11/9/17, 7:51 p.m. R14 was ambulating with CNA to room. Resident attempted to sit down, and was lowered to floor by CNA. Assisted resident to standing position. Checked for injury and pain, none noted. Resident identified as being lethargic. Predisposing factors were identified as R14 being drowsy, recent change in medications/new, impaired memory, ambulating with assist, and wanderer. In addition, R14 was identified as having poor vision, and less able to follow commands as evening progresses, related	F 689		

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to dementia. There was no assessment/analysis of the fall nor revised interventions identified as necessary.
(7) 11/21/17, 2:47 p.m. Resident started to sit on bathroom floor sliding down staff's leg as she was sitting. There was no injuries observed. Predisposing factors were identified as impaired memory and wandering. However, there was no analysis nor comprehensive assessment related to the fall.
(8) 11/21/17, 7:20 p.m. CNA heard noise and went into room 100, R14 was in doorway to room. The resident in room 100 was yelling for R14 to get out. The report indicated the CNA was redirecting R14 out of the room and R14 began to sit down, and was lowered to the floor to prevent injury. No injuries observed. Predisposing factors were identified as noise, poor lighting, confusion, drowsiness, impaired memory, wandering, and ambulating without assist. The report indicated R14 had knocked over the other resident's lamp which made a noise, and caused the other resident to yell. The report indicated R14 was visually impaired. An assessment/analysis of the fall was lacking nor were interventions revised as necessary to maintain safety..
(9) 11/21/17, 10:56 p.m. Resident found sitting on the floor next to her bed. Resident moved to place of safety. No injuries observed. Predisposing factors were identified as including: poor lighting, confusion, drowsiness, impaired memory, visual impairment, impaired safety awareness, and impaired judgement. The report indicated R14 had verbalized a need to use the toilet, had been assisted and urinated. A comprehensive assessment was lacking to indicate the repeat falls (3 falls/11/21) had been analyzed to determine whether interventions were

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effective and/or whether new interventions were required based on the results of the assessment.
(10) 12/4/17, 7:30 a.m. CNA opened door to room and found resident sitting on floor on buttocks. Resident stated "I was going to the bathroom." No injuries observed. Predisposing factors indicated R14 was confused, had impaired memory, and was ambulating without assist, wanderer. There was no analysis of the fall or any revised interventions identified.
(11) 12/26/17, 11:45 p.m. Resident's roommate came to nursing station visibly upset and said, "The tall lady fell". Staff went to resident [R14's] room and found R14 on her right side, eyes closed, against her closet door. Resident had previously had a boom box-type radio sitting on the counter, plugged into the wall. The report indicated the radio was on the floor near R14's feet. One of R14's drawers was open and R14 was unable to state what had happened. The staff had assessed R14 for injury and pain, and noted R14 had severe pain to in the right hip and shoulder with no rotation of the hip noted. R14 appeared to be sleeping, continued to be very sleepy, and staff were unable to perform neuro checks. The report indicated R14 was combative and violent with assessment, and was subsequently sent to the emergency department via ambulance. While at the hospital, an injury of a right hip fracture was identified. Predisposing factors were identified as including: furniture, confusion, drowsiness, gait imbalance, and impaired memory. Resident was in tennis shoes and socks, had been in bed with room light on. Chair between bed and where resident was found. Radio that had been on counter was on floor. Legally blind, vision very impaired, wanders incessantly. A comprehensive assessment related to the root cause of the fall with injury was

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lacking to determine whether current interventions were effective and/or new interventions were necessary.
(12) 1/25/18, 3:22 p.m. Staff had laid resident down to rest after lunch due to resident being restless and anxious. Resident was crying out. Resident was found on the floor lying on her back next to her chair in her room. When nurse walked into her room [R14] was lying on her left side with a pillow under her head that staff had placed at 1:50 p.m. Resident was asked what happened when she fell to the floor and resident replied, "Why should you need to know?" No injuries observed. Predisposing factors were identified as impaired memory. The report indicated R14 had been running a temperature the past few days, with current temperature 97.4, and indicated R14 was restless and anxious when up in her wheelchair, so staff had assisted her back into bed to rest after lunch. There was no analysis of the fall nor any revised interventions identified.
R14 was observed on 4/24/18 at 8:40 a.m. lying in bed with a concave mattress in place, a fall mat on the floor, and the bed was in the low position. R14 appeared to be sleeping. At 9:30 a.m., R14 remained in bed resting quietly. At 11:00 a.m., R15 was noted up in her wheel chair. R14 was observed to be layed back down in bed at 1:00 p.m.
During observation on 4/25/18, at 8:00 a.m. R14 was noted up in their wheelchair for breakfast. R14 appeared sleepy, was quiet and ate poorly at the meal. At 9:30 a.m., R14 was in bed resting. At11:30 am, R14 was up in her wheelchair for lunch. At 1:00 p.m., R14 was layed down in bed with a fall mat on the floor by her bed, and the bed in a low position. R14 was noted back up in her wheelchair at 4:00.

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F 689	Continued From page 22 During observation on 4/26/18, at 7:00 a.m. R14 was in bed asleep, with the fall mat on the floor and the bed in low position. No attempts to self transfer were noted during the course of the survey. During interview on 4/26/18, at 2:00 p.m. nursing assistant (NA)-D stated, "I have never seen her try to get up, she gets up in her chair and eats then goes back to bed. She has one of those scooped out mattresses and a fall matt on the floor." During interview on 4/26/18, at 2:53 p.m. the director of nursing (DON) said falls are reviewed at morning meetings. The DON stated, "I know we were one on one with her. No one was allowed to leave the day room when she was present. If they left they had to have a stand in [another staff member]." The DON did not know when the fall mat or concave mattress had been initiated and the DON could not verify whether any revised interventions were put into place for R14 after any of her falls. The DON stated, "We have a lot of verbal communication going on [with respect to falls], but no, I can't show you interventions." R15 R15's admission record identified an admission date of 9/1/17, with diagnosis including Alzheimers Disease, psychotic disorder with hallucinations and delusions, macular degeneration and bilateral osteoarthritis of the knee. R15's significant change MDS dated 12/8/17, identified severe cognitive impairment, extensive assistance of two staff with bed mobility, transfers, walking and toileting. The MDS also identified one fall without injury since the last assessment (9/7/17). The quarterly MDS dated 3/6/18, identified one fall since last assessment.	F 689		

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CROSSROADS CARE CENTER	965 MCMILLAN STREET WORTHINGTON, MN 56187

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The CAA dated 12/14/17, identified R15 was admitted from home. R15 had fallen on 9/1/17 while walking with family. No injuries were noted. She has balance problems and requires one or 2 staff assist with mobility, ambulation and transfers. She has vision problems and is hard of hearing. She is at risk for falls.
R15 observed in her room throughout the survey, either in bed or up in her recliner. R15's bed was in the low position and a fall mat was on the floor beside R15's bed.
R15's Risk for Falls dated 12/8/17, identified risks including intermittent confusion, fall in last 30 days prior to admission/entry or reentry and use of assistive devices. No fall risk score or analysis of the assessment were found in the record.
R15's fall incidents as follows:
(1) 11/22/17, 6:00 p.m. Heard call on radio for nurse to ambulance entrance, found resident and daughter in law on the ground. Resident had been in emergency room and family decided to transport resdient back to facility. Resident did not have walker with her. Family called for staff assistance but did not wait for staff to arrive. Daughter in law began to ambulate with R15, no gait belt or walker, and "apparently" resident's weak left foot became tangled with her right foot taking her down and daughter in law with her. Resident stated she had no pain then that she hurt everywhere. unable to describe further what happened. No injuries observed. Note resident had been ambulatory with walker day prior and family stated they did not realize extent of residents weakness and attempted to ambulate resident in to facilty without wait for staff to arrive to assist. Predisposing factors poor lighting, confused, gait imbalance, impaired memory, recent change in cognition, weakness, ambulating without assist. No analysis of fall or

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interventions identified.
(2) 1/20/18, 7:30 a.m. Resident was found lying on the floor at 7:30 a.m. next to her bed with her pillow under her head sleeping. Resident said "I couldn't find my bed, I laid on the floor." No injuries. Predisposing factors confused, ambulating with assist, using walker, resident's lights were off, only a lamp on in her room for light. Resident assist of one with walker, later in day was confirmed influenza A positive. No analysis of fall or interventions identified.
(3) 4/15/18, 3:51 p.m. Staff called nurses into resident's room this afternoon. resident was found lying on her right side with her right am/hand behind her. Resident's legs were out in front of her left arm resting on her left side. Resident's walker was on the right side of her close to the bed. There was blood on the floor next to her head. Resident has a bump with an open area on her right forehead/temple area. Nurse asked resident what she was trying to do/go when she fell. Resident replied "trying to get up." R15 was taken to the local hospital with a hematoma to her head. Predisposing factors were identified as: incontinence, gait imbalance, impaired memory, recent change in cognition, ambulating without assist. The report indicated R15 had self transferred from the recliner in her room before falling to the floor, and the recliner was reclined out with the foot rest elevated. There was no analysis of the fall or revised interventions identified.
R15's care plan dated 12/26/17, identified R15 had an actual fall with no injury. Interventions included: Continue interventions on the at-risk plan. For no apparent acute injury, determine and address causative factors of the fall. Monitor/document/report as needed for 72 hours to MD for signs or symptoms of pain, bruises,

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F 689	Continued From page 25 change in mental status, new onset confusion, sleepiness, inability to maintain posture, agitation. Pharmacy consult to evaluate medications. Provide activities that promote exercise and strength building where possible. Provide one to one activities if bed bound PT consult for strength and mobility. The NA visual/bedside kardex report dated 4/26/18, identified ensure the resident has unobstructed path to the bathroom. The resident refuses to wear glasses. take care with activities/care to provide for safety and promote independence. During interview on 4/26/18, at 2:53 p.m. the DON verified there had been no analysis of R15's falls, nor revised interventions put in place. The DON stated the care plan had not been updated, but should have been. A Fall assessment Policy dated 12/23/17, indicated: "All falls need to be evaluated for root cause. Proper interventions need to be put in place to ensure resident safety. All falls will have post fall assessment completed and care plan will be initiated." R28 R28's face sheet dated 4/26/18, identified diagnoses including Alzheimer's disease, dementia, syncope (fainting) and collapse, diabetes mellitus, and peripheral automomic neuropathy (nerve damage). R28's quarterly Minimum Data Set (MDS) assessment dated 3/29/18, indicated R28 needed extensive assistance with transfers and walking, had unsteady balance, and two or more falls since prior assessment without injury. The Care Area Assessment (CAA) related to falls dated 1/11/18, indicated R28 was at risk for falls, had impaired balance during transitions, required	F 689		

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staff assistance due to unsteadiness, had Alzheimer's disease, and was frequently incontinent of bladder. Staff were to assist with ambulation to ensure safety as a fall prevention. R28's care plan, last revised on 4/25/18, indicated R28 had limited physical mobility related to weakness, Alzheimer's disease, and had sustained a fall to knees on 4/25/18. Approaches included: (1) assist to safety of bed/recliner when is noted to be leaning and/or having increased weakness; (2) requires supervision by one staff to walk as tolerated. Review of R28's incident reports revealed the following falls:
(1) 2/21/18, at 2:47 p.m. found on floor of room, no injury. Predisposing situation factors: R28 requires assist of two for ambulation and was attempting to get out of bed. R28 has had a progressive decline in condition and spouse desires palliative care and hospice as condition declines toward end-stage dementia.
(2) 3/18/18, at 11:50 a.m. was found lying on the floor at east hall sitting area, no injury. No further analysis or interventions noted.
(3) 3/20/18, at 6:40 p.m. tipped over in chair at dining room table onto the floor, no injury. Predisposing situation factors: R28 had been leaning to the left side prior to supper. R28 is receiving physical therapy for increase of weakness and unsteadiness and had been positive for influenza A on 1/25/18.
(4) 4/24/18, at 8:10 a.m. was found lying on floor of room with left upper back resting on bedside table leg. R28 obtained two abrasions and skin tear to left upper back/shoulder area, and a bruise to left forearm. The bedside table was broke in half and R28 indicated he was "trying to get up and fell". Predisposing situation factors: ambulating without assist, wanderer, will get up

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F 689	Continued From page 27 on own and start walking. (5) 4/25/18, at 12:30 p.m. was found on knees in day room next to recliner he had been sitting in with foot rest still out, no injury. Predisposing situation factors: ambulating without assist during transfer. None of the incident reports identified interventions implemented post-falls. During intervew on 4/25/18, at 2:53 p.m. nursing assistant (NA)-A stated R28 had fallen, but indicated there were no specific fall interventions other than visually checking on R28 when passing by him. On 4/26/18, at 8:11 a.m. NA-B stated R28 had history of falling and indicated there were no fall interventions in place for R28. NA-B further indicated staff supervise him in the dayroom and assist as needed. When interviewed on 4/26/18, at 8:15 a.m. the director of nursing (DON) stated incidents related to falls were reviewed at interdisciplinary team (IDT) meetings every morning and weekly at a risk management meeting. The DON stated the team determines root cause and interventions if indicated; however, explained this documentation was lacking. The DON confirmed that although R28 had fallen on 2/21/18, 3/18/18, 3/20/18, 4/24/18, and 4/25/18; no interventions were implemented post-falls nor had risk factors been analyzed to ensure interventions were developed to prevent further falls. A facility policy titled, Fall Prevention dated 3/22/18, indicated all residents who are assessed as being at high risk for falls will be identified and individualized fall precautions will be developed for that resident. Preventative measures shall be taken to decrease the number of falls whenever possible.	F 689		

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F 756	Continued From page 28	F 756		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take	F 756		6/6/18

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F 756	Continued From page 29 when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the consultant pharmacist failed to identify and make recommendations related to the lack of timely tardive dyskinesia (TD) screenings (an assessment or involuntary movements) for 4 of 5 residents (R2,R21, R30 & R32) reviewed for unnecessary medications who were receiving an antipsychotic. Findings include: R2's Diagnosis Report dated 3/7/18, included diagnoses of major depressive disorder and psychotic disorder with hallucinations. R2's physician orders dated 3/7/18, included orders for Seroquel (an antipsychotic) 25 milligrams (mg) daily and Seroquel 50 mg at bedtime for psychotic disorder with hallucinations. The original start date for the orders was 10/1/17. R2's care plan last revised 4/9/18, indicated: Monitor/document/report PRN (as needed) any adverse reactions of psychotropic medications including tardive dyskenesia. Review of R2's medical record revealed no evidence a TD screening had been completed. Review of R2's pharmacy consultant notes did not reveal the missing TD screenings were identified on the irregularity reports to the facility. R21's Diagnosis Report dated 3/21/18, included diagnoses of dementia with behavioral disturbance, Alzheimer's disease, anxiety and depression. R21's physician orders dated 3/21/18, included an order for Zyprexa (an antipsychotic) 2.5 mg daily with an original start date of 3/8/18. A fax to the physician dated 3/7/18, indicated R21 had exhibited an increase in behaviors related to	F 756	F756 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to provide pharmacy consultation along with drug review and follow up with all pharmacy recommendations for MD review. R2, R21, R30, and R32 all were on psychotropics which were not assessed for TD per guidelines. After survey noted these concerns immediately DON was updated on AIMS assessment which is in point click care and available to staff to do assessment. AIMS was completed on residents identified during survey to ensure no adverse effects of psychotropic use. Use of psychotropic use was added to care plans. 2.Because residents receive psychotropics within facility it has potential to affect all residents. A pharmacy consultation was held to review AIMS and need for consultant to also review all residents. All residents receiving psychotropics had AIMS completed. The	

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F 756	Continued From page 30 aggressiveness and paranoia. R21 had also been physically aggressive with another resident. The fax further indicated the resident had previously been on Zyprexa 2.5 mg and Zoloft (an antidepressant) 50 mg. The Zoloft was decreased from 50 mg to 25 mg on 9/20/17. Request to consider restarting Zyprexa 2.5 mg daily and increase Zoloft back up to 50 mg once daily with intention of tapering back off Zyprexa once mood and behaviors had stabilized. Return fax from the physician dated 3/7/18 indicated new orders for Zyprexa 2.5 mg daily and Zoloft 50 mg daily. R21's care plan last revised 3/30/18, indicated: Monitor/document/report PRN (as needed) any adverse reactions of psychotropic medications including tardive dyskenesia. Review of R21's medical record revealed no evidence a TD screening had been completed. Review of R3's pharmacy consultant notes did not reveal the missing TD screenings were identified on the irregularity reports to the facility. When interviewed on 4/26/18, at 11:45 a.m. the director of nursing (DON) stated there was a form that is to be filled out for tracking of residents who require an every 6 month TD assessment. DON thought the TD assessments had been completed for R2 and R21. Staff had looked in the overflow files but could not locate one for either resident. DON stated R21 had been taken off Zyprexa for a period of time and recently was restarted due to paranoia and aggressive behavior. DON confirmed staff were unable to locate a current TD assessment since R21 restarted the Zyprexa. When interviewed on 4/26/18, at 3:46 p.m. the consulting pharmacist confirmed having "missed those" related to TD assessments for residents on antipsychotic medication.	F 756	policy on psychotropic medications been updated. Other residents were affected and AIMS completed. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 5/24/2018 all nursing staff will receive in-service training on monitoring for TD, AIMS and updating assessments quarterly and with significant changes. Also ensuring psychotropic use is care planned. 4.Effective 5/17/2018, a quality-assurance program was implemented under the supervision of the director of nurses to monitor resident medications and pharmacy follow up. The DON or designee will follow up on all pharmacy consultant recommendations immediately, meet with pharmacy consultant monthly to review all medication recommendations and ensure over next quarter all AIMS continue being evaluated as required. DON will complete 4 audits per week x 4 weeks, then 2 audits weekly x2 months to ensure compliance with follow up on consultation requests. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5. Pharmacy and DON will be responsible for this POC. 6.Compliance by June 6, 2018.	

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R30's Diagnosis Report dated 4/26/18, included diagnoses of altered mental status, dementia with behavioral disturbance, anxiety and delusional disorders.
R30's annual Minimum Data Set (MDS) dated 4/2/18, identified moderately impaired cognition and daily use of an antipsychotic medication.
R30's physician orders dated 4/25/18, included orders for Risperdal (antipsychotic medication) 0.25 mg one time daily related to delusional disorders.
R30's care plan last revised, 5/9/17, identified R30 used psychotropic medications related to behavior management and disease process. The care plan identified staff were to monitor for any adverse reactions of psychotropic medications including unsteady gait, tardive dyskinesia and

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F 756	Continued From page 32 extrapyramidal symptoms (EPS shuffling gait, rigid muscles, shaking). Review of R30's medical record revealed no evidence a TD screening had been completed. Review of R30's pharmacy consultant notes did not reveal the missing TD screenings were identified on the irregularity reports to the facility. R32's Diagnosis Report dated 4/26/18, included diagnoses of vascular dementia with behavioral disturbance and psychotic disorder with delusions. R32's annual MDS dated 4/4/18, identified severe cognitive impairment and daily use of an antipsychotic medication. R32's physician orders dated 4/26/18, included orders for Haldol (antipsychotic medication)0.25 mg twice daily for delusional thoughts and paranoia. R32's care plan last revised, 3/22/18, did not identify the use of antipsychotic medications Review of R32's medical record revealed no evidence a TD screening had been completed. Review of R32's pharmacy consultant notes did not reveal the missing TD screenings were identified on the irregularity reports to the facility. During interview on 4/25/18, at 12:40 p.m. the assistant director of nursing (ADON) stated she was unable to find a TD screening for R30 or R32.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following	F 758		6/6/18

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F 758	Continued From page 33 categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be	F 758		

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F 758	Continued From page 34 renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to complete timely tardive dyskinesia (TD) screenings (assessment for involuntary movements) for 4 of 5 residents (R2, R21, R30, R32) reviewed for unnecessary medications who were receiving an antipsychotic. Findings include: R2's Diagnosis Report dated 3/7/18, included diagnoses of major depressive disorder and psychotic disorder with hallucinations. R2's physician orders dated 3/7/18, included orders for Seroquel (an antipsychotic) 25 milligrams (mg) daily and Seroquel 50 mg at bedtime for psychotic disorder with hallucinations. The original start date for the orders was 10/1/17. R2's care plan last revised 4/9/18, indicated: Monitor/document/report PRN (as needed) any adverse reactions of psychotropic medications including tardive dyskenesia. Review of R2's medical record revealed no evidence a TD screening had been completed. R21's Diagnosis Report dated 3/21/18, included diagnoses of dementia with behavioral disturbance, Alzheimer's disease, anxiety and depression. R21's physician orders dated 3/21/18, included an order for Zyprexa (an antipsychotic) 2.5 mg	F 758	F758 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to follow guidelines regarding use of unnecessary psychotropic medications. For R2, R20, R30 and R32 the facility failed to ensure these residents who received their psychotropic medications had necessary assessment to ensure no side effects related to medication use. The pharmacy consultant also failed to put forth recommendations to follow up on TD monitoring. This negligent practice was determined to have occurred last year and was to be reviewed in QAPI which was also not completed. All medications have been reviewed with consultant and will be discussed at next QAPI. The framework has been set to ensure adequate follow up with dose reductions, proper diagnoses, target behaviors put in place on TAR and medications on care plan. MAR's and TAR's updated and care plans updated.	

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CROSSROADS CARE CENTER	965 MCMILLAN STREET WORTHINGTON, MN 56187

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F 758	Continued From page 35 daily with an original start date of 3/8/18. A fax to the physician dated 3/7/18, indicated R21 had exhibited an increase in behaviors related to aggressiveness and paranoia. R21 had also been physically aggressive with another resident. The fax further indicated the resident had previously been on Zyprexa 2.5 mg and Zoloft (an antidepressant) 50 mg. The Zoloft was decreased from 50 mg to 25 mg on 9/20/17. Request to consider restarting Zyprexa 2.5 mg daily and increase Zoloft back up to 50 mg once daily with intention of tapering back off Zyprexa once mood and behaviors had stabilized. Return fax from the physician dated 3/7/18 indicated new orders for Zyprexa 2.5 mg po (by mouth) daily and Zoloft 50 mg daily. R21's care plan last revised 3/30/18, indicated: Monitor/document/report PRN (as needed) any adverse reactions of psychotropic medications including tardive dyskenesia. Review of R21's medical record revealed no evidence a TD screening had been completed. When interviewed on 4/26/18, at 11:45 a.m. the director of nursing (DON) stated there was a form that is to be filled out for tracking of residents who require an every 6 month TD assessment. DON thought the TD assessments had been completed for R2 and R21. Staff had looked in the overflow files but could not locate one for either resident. DON stated R21 had been taken off Zyprexa for a period of time and recently was restarted due to paranoia and aggressive behavior. DON confirmed staff were unable to locate a current TD assessment since R21 restarted the Zyprexa.	F 758	2.Because many residents have orders for psychotropics, many are potentially affected by the cited deficiency. All residents have been reviewed for current psychotropic meds, for appropriate use, diagnosis, and monitoring for side effects. No other residents were affected. The policy on psychotropics medications has been reviewed and revised. 3.To enhance currently compliant operations and under the direction of the DON, on 5/24/2018 all nursing staff will receive in-service training on current CMS guidelines for use of psychotropic medications, identification and documentation of target behaviors, Trigger identification, non-pharmacological approaches, side effects of psychotropic meds and impact on resident condition and quality of life. Psychotropic medications will be reviewed at quarterly and annual reviews to determine need, effectiveness, and TD monitoring. Pharmacy consultant will review routinely for missing data and communicate findings to DON. 4.Effective 5/17/2018, a quality-assurance program was implemented under the supervision of the DON to monitor residents with orders for psychotropic meds. The DON or designee will follow up on all pharmacy consultant recommendations immediately, meet with pharmacy consultant monthly to review all medication recommendations and ensure over next quarter all AIMS continue being evaluated as required. DON will complete	

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F 758	Continued From page 36 The policy titled Psychotropic Medications, dated 12/23/17, included: AIMS (abnormal involuntary movement scale) will be performed on any resident on and [sic] antipsychotic on a quarterly basis [sic] changes will be reported to the physician. R30's Diagnosis Report dated 4/26/18, included diagnoses of altered mental status, dementia with behavioral disturbance, anxiety and delusional disorders. R30's annual Minimum Data Set (MDS) dated 4/2/18, identified moderately impaired cognition and daily use of an antipsychotic medication. R30's physician orders dated 4/25/18, included orders for Risperdal (antipsychotic medication) 0.25 mg one time daily related to delusional disorders. R30's care plan last revised, 5/9/17, identified R30 used psychotropic medications related to behavior management and disease process. The care plan identified staff were to monitor for any adverse reactions of psychotropic medications including unsteady gait, tardive dyskinesia and extrapyramidal symptoms (EPS shuffling gait, rigid muscles, shaking).	F 758	4 audits per week x 4 weeks, then 2 audits weekly x2 months to ensure compliance with follow up on consultation requests. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.The Pharmacy, SSC and DON will be responsible for this POC. 6.Compliance by June 6, 2018.	

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F 758	Continued From page 37	F 758		

Review of R30's medical record revealed no evidence a TD screening had been completed.

Review of R30's pharmacy consultant notes did not reveal the missing TD screenings were identified on the irregularity reports to the facility.

R32's Diagnosis Report dated 4/26/18, included diagnoses of vascular dementia with behavioral disturbance and psychotic disorder with delusions.

R32's annual MDS dated 4/4/18, identified severe cognitive impairment and daily use of an antipsychotic medication.

R32's physician orders dated 4/26/18, included orders for Haldol (antipsychotic medication)0.25 mg twice daily for delusional thoughts and paranoia.

R32's care plan last revised, 3/22/18, did not identify the use of antipsychotic medications

Review of R32's medical record revealed no evidence a TD screening had been completed.

Review of R32's pharmacy consultant notes did not reveal the missing TD screenings were identified on the irregularity reports to the facility.

During interview on 4/25/18, at 12:40 p.m. the assistant director of nursing (ADON) stated she was unable to find a TD screening for R30 or R32.

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F 758	Continued From page 38	F 758		
F 759 SS=E	. Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure insulin was administered per standard of practice during 3 of 5 insulin administration observations for 3 of 4 residents (R6, R13, & R22). The facility also failed to administer a scheduled pain medication (morphine sulfate) timely for 1 of 1 resident who complained of pain; and for 2 of 4 residents (R22, R32) observed who received insulin prior to meals. The facility's medication error rate was greater than 5% at 17.65 percent (%) rate. Findings include: On 4/24/18, at 11:45 a.m. licensed practical nurse (LPN)-C was observed preparing and administering insulin to R13 via a NovoLog FlexPen. LPN-A removed the cap off the FlexPen then attached a disposable needle to the rubber stopper at end of the pen. After attaching the needle to the FlexPen, LPN-A then dialed up 18 units and administered the insulin into R13's abdomen. LPN-C did not cleanse the rubber stopper with an alcohol swab prior to putting on	F 759	F759 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to safely administer medications to the residents. Insulin was not administered correctly to 3 residents (R6, R13, and R22), R14 didn't get appropriate pain medication and R22 and R32 didn't get insulin prior to meals. When the surveyor notified nurse leadership regarding errors and magnitude of errors immediately staff were addressed, educated and counseled on poor practice. Every effort was made immediately to ensure same mistakes would not happen again.	6/6/18

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F 759	Continued From page 39 the disposable needle nor did he prime the FlexPen prior to dialing up and administering the prescribed insulin dose. When interviewed immediately following administration, LPN-C confirmed not swabbing the insulin pen port with alcohol prior to applying the needle. LPN-C stated he always swabbed the top of insulin vials with alcohol prior to drawing up the medication but never did with the insulin pens. LPN-C further confirmed he had not primed the insulin pen prior to dialing up the dosage stating he used to do that but hadn't for awhile because somebody told him not to. The NovoLog FlexPen manufacturer's Instructions For Use included: A. Pull off the pen cap. Wipe the rubber stopper with an alcohol swab. B. Remove the protective tab from a disposable needle. Screw the needle tightly onto your FlexPen. C. Pull off the big outer needle cap. D. Pull off the inner needle cap and dispose of it. Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: E. Turn the dose selector to select 2 units. F. Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push-button all the way in. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. If you do not see a drop of insulin after 6 times, do not use the NovoLog FlexPen . On 4/26/18, at 7:45 a.m. LPN-B was observed preparing and administering insulin to R6 via a Humalog KwikPen. LPN-B removed the cap off	F 759	2.Because all residents rely on staff for safely administering medications all are potentially affected by the cited deficiency, staff were reminded to ensure staff follow proper indication and administration and always use the 5R's when giving medications. All resident's medications and orders reviewed. No other residents were affected. The policy on medication administration has been updated including review of insulin policy. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 5/24/2018 all nursing staff will be in-serviced on safe medication administration, medication errors, review survey findings, and insulin administration protocol and practice as well as following MD order. 4.Effective 5/17/2018, a quality-assurance program was implemented under the supervision of the director of nurses to monitor medication administration. The director of nurses or designated quality-assurance representative will perform the following systematic audits: medication competency on all staff, complete med pass audits of 3 staff per week x 4 weeks, then 1 staff weekly x2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action.	

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F 759	Continued From page 40 the KwikPen then attached a disposable needle to the rubber stopper at end of the pen. After attaching the needle to the KwikPen, LPN-B then dialed up 5 units and administered the insulin into R6's abdomen. LPN-B did not cleanse the rubber stopper with an alcohol swab prior to putting on the disposable needle nor prime the FlexPen prior to dialing up and administering the prescribed insulin dose. On 4/26/18, at 9:22 a.m. LPN-B was observed preparing and administering insulin to R22 via a Humalog KwikPen. LPN-B removed the cap off the KwikPen then attached a disposable needle to the rubber stopper at the end of the pen. After attaching the needle to the KwikPen, LPN-B dialed up 6 units and administered the insulin into R22's abdomen. LPN-B did not cleanse the rubber stopper with an alcohol swab prior to putting on the disposable needle nor prime the FlexPen prior to dialing up and administering the prescribed insulin dose. When interviewed immediately following insulin administration, LPN-B confirmed not swabbing off the ends of the ports on the insulin pens for R6 or R22 as the needle she applied was sterile. LPN-B further confirmed not priming the insulin pens prior to dialing up the dosage for both R6 and R22. The Humalog KwikPen manufacturer's Instuctions for Use included: Step 1: Pull the Pen Cap straight off. Do not remove the Pen Label. Wipe the Rubber Seal with an alcohol swab. Step 2: Check the liquid in the Pen. Humalog should look clear and colorless. Do not use if it is cloudy, colored, or has particles or clumps in it. Step 3: Select a new needle. Pull off the Paper Tab from the Outer Needle Shield. Step 4: Push the capped Needle straight onto	F 759	5.The Pharmacy and DON will be responsible for this POC. 6.Compliance by June 6, 2018.	

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the Pen and twist the Needle on until it is tight. Step 5: Pull off the Outer Needle Shield. Do not throw it away. Pull off the Inner Shield and throw it away. Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 6: To prime your Pen, turn the Dose Knob to select 2 units. Step 7: Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Step 8: Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and "0" is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle. If you do not see insulin, repeat priming steps 6 to 8, no more than 4 times. If you still do not see insulin, change the Needle and repeat priming steps 6 to 8.

On 4/25/18, at 1:27 p.m. registered nurse (RN)-A was observed entering the east memory care unit and began working on the east medication cart. Previously LPN-A had been observed administering the noon medications on the east unit and also assisting residents with eating. When interviewed at that time RN-A indicated LPN-A was leaving for the day and RN-A would be picking up the medication pass for her.

On 4/25/18 at 1:39 p.m. RN-A was observed setting up and administering R22's scheduled insulin via a Humalog KwikPen. The order on the pen indicated: Humalog KwikPen 100/ml inject 6 units SQ (subcutaneously) tid (three times a day) before meals. R22's blood sugar prior to lunch

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F 759	Continued From page 42	F 759		

was 309. When asked why R22's insulin was not given prior to the meal RN-A stated they make sure R22 is going to eat her meal prior to administering the insulin. RN-A further stated sometimes the resident refuses to eat and her blood sugar would bottom out if insulin was given prior to the meal. When entering R22's room she was observed lying in bed taking a nap as she had finished her noon meal.

R22's signed physician orders dated 4/25/18, included: Humalog KwikPen 100 Unit/ml (milliliter) inject 6 units subcutaneously with meals related to type 2 diabetes without complications. Hold when resident does not eat.

On 4/25/18, at 2:00 p.m. RN-A was observed setting up and administering R32's sliding scale insulin to be administered prior to meals. The order on the insulin pen indicated: Humalog Kwikpen 100/ml inject 0-11 units per sliding scale SQ before meals. R32's blood sugar value taken before lunch was 268 indicating R32 was to receive 8 units of insulin. When entering R32's room she was observed lying in bed sleeping; the resident had finished her noon meal. When interviewed immediately following R32's insulin administration, RN-A confirmed many times the residents who receive insulin have it administered after eating to assure the resident had eaten first. RN-A confirmed 2:00 p.m. was too late to be administering R32's insulin. RN-A could not say what happened prior to her coming into work that had made the medication pass fall so far behind.

R32's signed physician orders dated 4/4/18, included: Humalog solution. Inject as per sliding scale: if 150 - 200 = 4 units; 201 - 250 = 6 units; 251 - 300 = 8 units; 301 - 350 = 10 units; 351 -

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F 759	Continued From page 43 400 = 12 units, subcutaneously before meals for diabetes. Call PCP (primary care provider) for blood glucose > (greater than) 400. On 4/25/18, at 2:18 p.m. registered nurse (RN)-A was observed administering R14's 12:00 p.m. scheduled dose of morphine sulfate 100 milligrams (mg) per 5 milliliters (ml) 0.25 ml under R14's tongue via a small syringe. RN-A asked R14 if she was having any pain and she indicated yes; RN-A asked R14 if the pain was in her hip and again she indicated yes. R14's signed physician orders dated 3/21/18, included: Morphine Sulfate solution 5 mg/ml. Give 0.25 ml sublingually three times a day for pain and SOB (shortness of breath) and anxiety. R14's medication administration record dated April 2018, indicated R14's morphine sulfate was scheduled at 8:00 a.m., 12:00 p.m., and 4:00 p.m. When interviewed on 4/25/18, at 3:50 p.m. surveyor informed the director of nursing (DON) many medications were administered late during the noon medication pass; including insulin and pain medication. DON stated being unaware the medication pass had fallen behind and indicated had she known, would not have instructed LPN-A to assist residents with eating. When interviewed on 4/26/18, at 3:46 p.m. the consulting pharmacist indicated the timeliness of R22 and R32's late insulin administration would not be considered a significant med (medication) error though definitely was a med error. The pharmacist further stated being more concerned with residents receiving scheduled pain medication late.	F 759		

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F 759	Continued From page 44 When interviewed on 4/26/18, at 4:42 p.m. the DON confirmed nurses should be priming the insulin pens prior to dialing up the dosage. The policy titled Insulin Administration dated 12/23/18, included: Preparing preloaded pen device. Attach a pen needle. Prime pen by dialing up 2 units. Point pen upwards and depress injector button. Ensure insulin is expelled from needle - repeat priming process if no insulin seen. The policy titled Medication Administration dated 12/23/17, included: 4. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).	F 759		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		6/6/18

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F 812	Continued From page 45 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure potentially hazardous foods were stored in a manner to prevent the growth of pathogenic microorganisms, and failed to ensure food items in the central kitchen cooler were labeled and dated. This had the potential to affect all 34 residents who ate food from the kitchen. Findings include: During the initial kitchen tour on 4/23/18, at 1:45 p.m. the following food storage problems were observed and confirmed by the dietary manager (DM): 1) Refrigerator labeled #1 contained open multi-serve juice boxes that were not dated and one Styrofoam container that was not labeled or dated that the DM stated was leftovers brought in for a resident by family. DM verified that it should have been dated and labeled. 2) Refrigerator labeled #2 did not contain a thermometer to determine temperature. DM verified there was not a thermometer in the refrigerator but should be. 3) Walk in cooler contained food storage containers of shredded cheese, shredded lettuce, and roast beef sandwich meat with no labels or dates. The walk in cooler also contained a food storage container of hard boiled eggs labeled as turkey with a prep date of 3/8/18. DM verified that the food storage containers should all have been labeled and dated. 4) Freezer labeled #2 containing ice cream and frozen garlic bread slices did not contain a	F 812	F812 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to ensure healthy and safe meal service. Some of the many ways that this has been done is ensuring thermometers were replaced in kitchen and the importance of dating all open containers. After the surveyor reported finding expired dates or undated items in kitchen it was determined staff were not properly managing expired foods. Immediately the dietary manager threw out items and updated staff to monitor dates and milk in fridge removed, all thermometers replaced and monitored daily. 2.Because all residents receive their meals here in facility all are potentially affected by the cited deficiency, 4/26/2018, the dietary manager did deep clean of the fridge to remove all outdated items. Cleaning out fridge items that are expired is now done daily with kitchen cleaning schedule and temperatures monitored daily to assure temps cooled	

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F 812	Continued From page 46 thermometer so was unable to determine the temperature of the freezer. The DM verified there was not a thermometer in the freezer but there should have been. 5) Cooler designated as the milk cooler temperature 46 degrees Fahrenheit contained four gallons of milk with an outdate of 4/19/18 and three gallons of milk with an outdate of 5/1/18. DM verified temperature was out of safe food cooling limits and that the milk should have been discarded after the expiration date. The DM stated residents had not been served any milk out of that cooler and the milk not outdated would be moved to the walk in cooler. Review of the Kitchen Sanitation policy, effective 12/23/17, directed to log fridge temps every shift. The Refrigerator/Freezer Temperatures log was not available during the initial kitchen tour, but was provided by the DM 4/23/18, at 4:50 p.m. and one temperature per day was completed up to 4/23/18. On 4/25/18, at 2:30 p.m. The posted Refrigerator/Freezer Temperatures log was reviewed in the kitchen and no temperatures were logged on 4/24/18 and 4/25/18. Review of the facility policy Food Brought by Family/Visitors indicated perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's name, the item, and the "use by" date.	F 812	enough to serve safely. 3.To enhance currently compliant operations and under the direction of the director of dietary, on 5/17/2018 dietary staff reviewed proper storage and dates with dietary manager to ensure all items are safe to serve. All dietary staff have completed required in-service. 4.Effective 5/17/2018, a quality-assurance program was implemented under the supervision of the director of dietary in conjunction with dietician to monitor fridge for expired items and log temperatures. The director of dietary or designated quality-assurance representative will perform audits of dates and temps to be done 2x per week for 4 weeks then 1x per week for 2 months to ensure compliance via dietary manager or designee. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly QAPI meeting for further review or corrective action. 5.Dietary manager and maintenance will be responsible for this POC. 6.Compliance by June 6, 2018.	
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program.	F 865		6/6/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245395	A. BUILDING _____ B. WING _____	04/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 865	Continued From page 47 §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality assessment and assurance (QAA) committee monitored compliance related to tardive dyskenesia (TD) screenings for residents receiving antipsychotic medication to ensure correction was achieved and sustained since the previous survey. This resulted in lack of TD monitoring for 4 of 5 residents (R2, R21, R30, & R32) reviewed for unnecessary medications. Findings include: Review of the Quality Assurance (QA) Meeting minutes indicated the committee met on a quarterly basis. Review of the meeting dates since the last annual survey on 8/17/17, included: 10/18/17, 1/17/18, with the next meeting scheduled the week of 5/6/18. The committee attendees included the administrator, DON, medical director, social service director, activities director, dietary supervisor, and medical records	F 865	F865 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to ensure that the Quality Assurance Performance Improvement committee identifies and develops appropriate action plans related to system failures. The facility failed to have appropriate action plans related to system failures including TD monitoring as well as areas determined survey to be noncompliant as present system was not reviewing operations, identifying OFIs,	

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F 865	Continued From page 48 director. The QA Meeting minutes dated 10/18/17, included the following: Psych med monitoring: DISCUS (Dyskinesia Identification System: Condensed User Scale - an assessment to evaluate involuntary movements) to be completed with psych meds that can have tardive dyskinesia side effects. Updates have been made in the MAR (medication administration record) to relay possible TD symptoms. The QA meeting minutes dated 1/17/18, did not address continued monitoring for completion of TD assessments for residents receiving antipsychotic medications. Interview with the DON on 4/26/18, at 4:14 p.m. confirmed the deficient practice related to TD monitoring identified at the time of the previous survey continued to be an issue. DON stated the deficiency had been corrected following the previous survey but wasn't sure what happened since that time. DON confirmed the QAA committee was not involved with monitoring to assure residents on antipsychotic medications had a current TD assessment on file to sustain compliance. The policy titled Psychotropic Medications, dated 12/23/17, included: AIMS (abnormal involuntary movement scale) will be performed on any resident on and [sic] antipsychotic on a quarterly basis [sic] changes will be reported to the physician. See F756 and F758.	F 865	prioritizing OFIs, determining the root cause and implementing PIPs. In review of system it was determined that QAPI had previously been ineffective. Administrator educated everyone on the QAPI program, the guidelines, processes and how to analyze data, etc. to begin to effectively address systemic failures to improve quality at facility. 2.Lack of appropriate action plans for system failures can affect all residents at the facility. After identifying system failures from survey, areas were identified and brought to QAPI on 5/17/2018. At this meeting, opportunities for improvement were identified, prioritized, root cause was determined, and performance improvement plans were initiated, reviewed and continue to be monitored. 3.To enhance currently compliant operations and under the direction of the Administrator, education reviewed the elements and goals of the QAPI program, assistance and tools for accurate data review, and proper identification of root cause while assuring goals are SMART (specific, measurable, attainable, realistic and time oriented). All staff will receive in-service training on 05/24/18 regarding QAPI program, who is on the committee and their roles, what is discussed, frequency of meetings, who to report suggestions to bring to QAPI, where monthly posting of review of prior months QAPI are, etc. 4.The QA committee will meet quarterly to	

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F 865	Continued From page 49	F 865	discuss action plans related to deficiencies noted during survey, review and analyze audits and determine appropriate continued monitoring or system changes in addition to other items already identified on the QAPI plan agenda. The medical director and pharmacy consultant will be present at a minimum quarterly; if not present minutes will have submitted to them prior to meeting to allow for input during meeting, then will be reviewed and signed monthly. Audits are in place and reviewed during QAPI. After QAPI the minutes and supporting documentation will be shared with staff and if compliance issue brought to RDCS. This plan of correction will be monitored at the quarterly QAPI meeting and audits to continue until such a time that shows consistent substantial compliance with the regulations and the facilities' QAPI plan has been met, as determined by a representative of the regional executive team. 5.The Administrator or designee will be responsible for this POC. 6.Compliance by June 6, 2018.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		6/6/18

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F 880	Continued From page 50 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880		

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F 880	Continued From page 51 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to clean an insulin pen with alcohol prior to placing the needle on the pen for 3 of 4 residents (R6, R13, & R22) observed during insulin administration. Findings include: On 4/24/18, at 11:45 a.m. licensed practical nurse (LPN)-C was observed preparing and administering insulin to R13 via a NovoLog FlexPen. LPN-A removed the cap off the FlexPen then attached a disposable needle to the rubber stopper at end of the pen. After attaching the needle to the FlexPen, LPN-A then dialed up 18 units and administered the insulin into R13's abdomen. LPN-C did not cleanse the rubber stopper with an alcohol swab prior to putting on	F 880	F880 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to provide infection prevention practices. Upon survey it was noted that staff did not clean insulin pens with alcohol to sanitize properly. Deficiency was discussed with nursing staff and education provided.	

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F 880	Continued From page 52 the disposable needle nor did he prime the FlexPen prior to dialing up and administering the prescribed insulin dose. When interviewed immediately following administration, LPN-C confirmed not swabbing the insulin pen port with alcohol prior to applying needle. LPN-C stated he always swabs the top of insulin vial with alcohol prior to drawing up the medication but never did with the insulin pens. LPN-C further confirmed he had not primed the insulin pen prior to dialing up the dosage stating he used to do that but hadn't for awhile because somebody told him not to. The NovoLog FlexPen manufacturer's Instructions For Use included: A. Pull off the pen cap. Wipe the rubber stopper with an alcohol swab. B. Remove the protective tab from a disposable needle. Screw the needle tightly onto your FlexPen. On 4/26/18, at 7:45 a.m. LPN-B was observed preparing and administering insulin to R6 via a Humalog KwikPen. LPN-B removed the cap off the KwikPen then attached a disposable needle to the rubber stopper at end of the pen. After attaching the needle to the KwikPen, LPN-B then dialed up 5 units and administered the insulin into R6's abdomen. LPN-B did not cleanse the rubber stopper with an alcohol swab prior to putting on the disposable needle nor prime the FlexPen prior to dialing up and administering the prescribed insulin dose. On 4/26/18, at 9:22 a.m. LPN-B was observed preparing and administering insulin to R22 via a Humalog KwikPen. LPN-B removed the cap off the KwikPen then attached a disposable needle to the rubber stopper at the end of the pen. After attaching the needle to the KwikPen, LPN-B	F 880	2. Because many resident's use insulin, many are potentially affected by the cited deficiency. All residents on who use insulin pens were reviewed and procedure reviewed. Policy reviewed. 3. To enhance currently compliant operations and under the direction of the director of nurses, on 5/24/2018 all nursing staff will be in-serviced on basic infection prevention and disinfecting insulin pens. 4. Effective 5/17/2018, a quality-assurance program was implemented under the supervision of the DON to monitor cleaning of insulin pens. The DON or designated quality-assurance representative will perform the following systematic audits on residents with insulin pens; 3 residents per week x 4 weeks, then 1 resident weekly x2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5. The DON will be responsible for this POC. 6. Compliance by June 6, 2018.	

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F 880	Continued From page 53	F 880		

dialed up 6 units and administered the insulin into R22's abdomen. LPN-B did not cleanse the rubber stopper with an alcohol swab prior to putting on the disposable need nor prime the FlexPen prior to dialing up and administering the prescribed insulin dose. When interviewed immediately following insulin administration, LPN-B confirmed not swabbing off the ends of the ports on the insulin pens for R6 or R22 as the needle she applied was sterile. LPN-B further confirmed not priming the insulin pens prior to dialing up the dosage for both R6 and R22.

The Humalog KwikPen manufacturer's Instuctions for Use included: Step 1: Pull the Pen Cap straight off. Do not remove the Pen Label. Wipe the Rubber Seal with an alcohol swab.

When interviewed on 4/26/18, at 3:46 p.m. the consulting pharmacist confirmed staff should be cleansing the port of insulin pens with an alcohol wipe prior to applying the needle per best practice.

When interviewed on 4/26/18, at 4:42 p.m. the director of nursing (DON) confirmed nurses should be priming the insulin pens prior to dialing up the dosage. When asked about swabbing off the port of the insulin pen with an alcohol wipe the DON stated she hadn't really thought about it but it would probably be a good idea.

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	245395	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/25/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Crossroads Care Center was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/20/2018

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

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K 000	Continued From page 1 St. Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Crossroads Care Center was constructed as follows: The original building was constructed in 1953, is one-story in height, has a full basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1968 Addition is one-story in height, has a full basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The facility has smoke detection in the corridors and spaces open to the corridors, which are monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 42 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to maintain the automatic sprinkler system in accordance with 9.7.5, 9.7.7, 9.7.8, and NFPA 25. This deficient practice could affect 35 out of 35 residents. Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily	K 353	K353 1. The Maintenance Supervisor will take over the duties of making sure the sprinkler system is tested on a quarterly basis. Midwestern Mechanical, Inc. conducts a semi-annual test and annual test of the sprinkler system. 2. The sprinkler system was checked on 3/20/18. The system test was provided by Midwestern Mechanical, Inc. The water system supply source is 4" dry - 3" wet. 3. The next completion date for testing and maintenance of the sprinkler system	6/4/18

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	245395	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/25/2018**

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K 353	Continued From page 3 available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 FINDINGS INCLUDE: On facility tour between 9:00 AM and 12:00 PM on 04/25/2018, during documentation review, documentation could not be provided to show that a quarterly fire sprinkler inspection occurred during the 2nd and 3rd quarters of 2017. This deficient practice was verified by the Facility Maintenence Director.	K 353	will be on or before 6/20/18. 4. Documentation from Midwestern Mechanical, Inc. shows that they did maintenance and testing of the sprinkler system on 3/20/18. 5. The Maintenance Director, Randy Graham will be responsible for the for the correction and monitoring to prevent a reoccurrence of the deficiency. 6. Compliance by 6/4/18.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that	K 363		6/4/18

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	245395	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/25/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 4 do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to maintain portable fire extinguishers in accordance with NFPA 80. The deficient practice could affect 35 out of 35 residents. Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke	K 363	K363 1. The Maintenance Supervisor will conduct an Annual Fire and Smoke Door inspection yearly and document that it has been done. 2. The Maintenance Supervisor completed the inspection of the Fire and Smoke Doors on 5/10/18 and 5/11/18. 3. The Maintenance Supervisor, Randy Graham will be responsible for the	

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	245395	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/25/2018**

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K 363	Continued From page 5 compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. FINDINGS INCLUDE: On facility tour between 9:00 AM and 12:00 PM on 04/25/2018, documentation review revealed that not all the required required fire/smoke doors are being documented during the Annual Fire and Smoke Door Inspection per NFPA 80. This deficient practice was verified by the Facility Maintenance Director.	K 363	correction and monitoring to prevent reoccurrence of the deficiency. 4. Compliance by 6/4/18.	
K 521	HVAC	K 521		6/4/18

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	245395	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/25/2018**

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K 521 SS=F	Continued From page 6 CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview, the Facility failed to ensure that the fire/smoke dampers were maintained according to 9.2 and in accordance with the manufacturer's specifications. The deficient practice could affect 35 out of 35 residents. HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 FINDINGS INCLUDE: On facility tour between 9:00 AM and 12:00 PM on 04/25/2018, documentation could not be provided that indicated the fire/smoke damper inspection had occurred within the past 4 years. This deficient practice was verified by the Facility Maintenance Director.	K 521	K521 1. The Maintenance Supervisor will take over the duties of making sure that the HVAC- Fire/Smoke Damper inspection has occurred every 4 years. 2. The HVAC- Fire/ Smoke Damper inspection will be tested on or before 6/1/18 by Automated Building Controls. 3. The Maintenance Supervisor, Randy Graham will be responsible for the correction and monitoring to prevent a reoccurrence of the deficiency. 4. Compliance by 6/4/18.	
K 712	Fire Drills	K 712		6/4/18

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K 712 SS=E	Continued From page 7 CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview, the Facility failed to conduct Fire Drills in accordnance with 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7. This deficient practice could affect 35 of 35 residents. Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7. FINDINGS INCLUDE:	K 712	K712 1. The Maintenance Supervisor will take over the duties of making sure that the DACT system monthly test is tested properly and that documentation shows that the signal time was verified by the monitoring company and a code number or name was given of who verified it. 2. A fire drill was done on 5-14-18 by the Maintenance Supervisor and the Environmental Service Director. Documentation shows that the DACT system was properly tested and was verified by the monitoring company. A signal time and verified name of Pedro # 759 was given to the Maintenance Supervisor to document on the fire drill sheet. 3. The Maintenance Supervisor, Randy Graham will be responsible for the	

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K 712	Continued From page 8 On facility tour between 9:00 AM and 12:00 PM on 04/25/2018, during documentation review, it was revealed that the DACT system monthly test was not documented for the 2nd shift of the 1st quarter of 2018. This deficient practice was verified by the Facility Maintenance Director.	K 712	correction and monitoring to prevent a reoccurrence of the deficiency. 4. Compliance by 6/4/18.	
K 914 SS=E	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to maintain electrical recepatacles in	K 914	K914	6/4/18

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K 914	Continued From page 9 accordance with NFPA 99. The deficient practice could affect 35 out of 35 residents. Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99). FINDINGS INCLUDE: On facility tour between 9:00 AM and 12:00 PM on 04/25/2018, it was revealed that not all of the testing procedures were being conducted during the electric receptacle testing. The electrical receptacles must receive the following inspections: 1.The physical integrity of each receptacle shall be confirmed by visual inspection. 2. The continuity of the grounding circuit in each electrical receptacle shall be verified.	K 914	1. The Maintenance Supervisor will take over the duties of making sure that the electric receptacles are maintained in accordance to NFPA 99. 2. The Maintenance Supervisor will verify the following inspections during the electrical receptacle testing in the resident rooms: a. The physical integrity of each receptacle shall be confirmed by visual inspection. b. The continuity of the grounding circuit in each receptacle shall be verified. c. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed. d. The retention force of the grounding blade of each receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz). 3. The electrical receptacle testing in each resident room will be completed by the Maintenance Supervisor on or before 5-25-18. 4. Records will be maintained by the Maintenance Supervisor of the required tests, associated repairs or modifications, containing date, room or area tested and results. 5. The Maintenance Supervisor, Randy Graham will be responsible for the correction and monitoring to prevent the reoccurrence of the deficiency.	

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K 914	Continued From page 10 3. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed. 4. The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz). This deficient practice was verified by the Facility Maintenance Director.	K 914	6. Compliance by 6/4/18.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by:	K 920		6/4/18

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K 920	Continued From page 11 Based on observation and interview, the Facility failed to comply with 10.2.4 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5.This deficient practice could affect 35 of the 35 residents. Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 FINDINGS INCLUDE: On facility tour between 9:00 AM and 12:00 PM on 04/25/2018, during the inspection, a extension cord was observed being used as a source of fixed wiring in the Boiler Room. This deficient practice was verified by the Facility	K 920	K920 1. The Maintenance Supervisor will take on the duties of making sure that no extension cords are used in the Boiler Room as a source of fixed wiring. 2. On 4/27/18 the extension cord in the Boiler Room was removed by the Maintenance Supervisor and a new outlet was installed on the wall on 4/27/18. 3. The Maintenance Supervisor, Randy Graham will be responsible for the correction and monitoring to prevent a reoccurrence of the deficiency. 4. Compliance by 6/4/18.	

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K 920	Continued From page 12 Maintenance Director.	K 920		