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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 598J

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245251**
2.STATE VENDOR OR MEDICAID NO.
(L2) **861347800**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/28/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **24** (L18)
13.Total Certified Beds **24** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date : 12/13/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: 12/31/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/06/2022
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 25, 2022

CMS Certification Number (CCN): 245251

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

Dear Administrator:

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 January 20, 2022 the above facility is certified for:

24 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 24 skilled nursing facility beds. You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 25, 2022

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

RE: CCN: 245251
Cycle Start Date: October 28, 2021

Dear Administrator:

On November 23, 2021, we notified you a remedy was imposed. On January 24, 2022 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 20, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 23, 2021 be discontinued as of January 20, 2022. (42 CFR 488.417 (b))

However, as we notified you in our letter of November 23, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 23, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 598J

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00470

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245251**
2.STATE VENDOR OR MEDICAID NO.
(L2) **861347800**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/28/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **24** (L18)
13.Total Certified Beds **24** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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 :
Jamie Boser, HFE - NE II 12/13/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 12/31/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
November 23, 2021

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

RE: CCN: 245251
Cycle Start Date: November 23, 2021

Dear Administrator:

On October 28, 2021, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 23, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 23, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 23, 2021. 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.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 23, 2021. the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Riverview Hospital & Nursing Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 23, 2021. You will receive further information regarding this from the State agency. 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.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 28, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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 (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
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
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 10/25/21 through 10/28/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 10/25/21 through 10/28/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5251042C (MN77830); however, no deficiencies were cited due to actions implemented by the facility prior to survey. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/29/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 validate that substantial compliance with the regulations has been attained.	F 000		
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 ensure an allegation of resident to resident abuse was immediately reported to the	F 609	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists.	12/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 2 State Agency (SA) 2 of 2 residents (R122, R10) reviewed who were involved in an allegation of resident to resident abuse. Findings include: R122's admission Minimum Data Set (MDS) dated 9/8/21, identified R122 had severe cognitive impairment and was independent with walking. R122 had verbal and physical behaviors directed towards other 1 to 3 days, other behaviors not directed at others 1 to 3 days, refusal of cares 1 to 3 days and wandering 4 to 6 days and would intrude on others privacy during a 7-day period. Diagnoses include Alzheimer's disease, anxiety disorder and dementia with behavioral disturbance. R10's annual Minimum Data Set (MDS) dated 8/11/21, indicated R10 had severe cognitive impairment and required extensive assistance with all activities of daily living (ADL's). Diagnoses included Alzheimer's disease. R10's progress notes identified registered nurse (RN)-A recorded late entry on 10/28/21. for an incident that occurred on 10/20/21, at 5:36 p.m.. R10 was struck on the right side of the face by another resident [R122] and immediate interventions included separating the residents and monitoring R10 for bruising and injuries. The facility's Vulnerable Adult Investigation Notes dated 10/19/21, indicated on 10/19/21, R10 was struck on the right side of the face by another resident [R122]. There was no evidence the incident between R122 and R10 was reported to the SA by the	F 609	This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: The report was filed on 12/01/2021 to the SA. 2. Identification of other residents having the potential to be affected was accomplished by: Upon chart review, no other allegations that should have been reported were identified in the past 60 Days. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service education program was conducted on 11/15/2021 by the Director of Nursing Services and the Administrator with all direct care staff addressing circumstances that require reporting including appropriate timeframes. Education stated that staff are to file a VA report or report to the Administrator as soon as possible but no longer than two hours after an incident. Currently policy states . The Director of Nursing Services, Administrator, or designee will: a. Notify the appropriate agencies immediately: as soon as possible, but no later than 2 hours after discovery of the incident. 4. How the corrective action(s) will be monitored to ensure the practice will not recur:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 3 facility. During interview on 10/27/21, at 2:21 p.m. RN-A stated R10 was slapped by another resident on 10/17/21. At the time, R122 and R10 were separated and monitored by two staff members. All other facility residents were monitored and kept safe from the AP. The director of nursing (DON) and the administrator determined not to report the incident to the SA because the R122 had not targeted R10. - At 4:04 p.m. the administrator stated the incident was not reported because R10 was not harmed by R122 and therefore, did not need to be reported. The facility Abuse Prevention Plan revised 6/8/21, identified abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The plan further identified "willful" as the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The plan directed alleged violations involving abuse were to be reported immediately, but no later than 2 hours after the allegation.	F 609	The Director of Nursing audited all residents progress notes for the past 60 days and there were no findings of abuse that went unreported. The Director of Nursing, or Designee sill continue to audit progress notes on all residents daily over the next four weeks or until the Quality Assurance committee indicates that substantial compliance has been met. This plan of correction will be monitored at the every other month at the Quality Assurance meeting until such time consistent substantial compliance has been met.	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab,	F 661		12/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 4 radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive discharge summary, including a recapitulation of stay was completed, and provided at the time of transfer to ensure continuity of care for 1 of 1 resident (R22) who was reviewed for discharge practices. Findings include: R22's admission Minimum Data Set (MDS) dated 9/1/21 identified severe cognitive impairment and was an extensive assist for dressing, toilet use and personal hygiene. R22's diagnoses included recent joint replacement surgery, dementia, epilepsy and rhabdomyolysis (a breakdown of	F 661	Immediate action(s) taken for the resident(s) found to have been affected include: On 11/29/2021 a discharge assessment note was entered by the Director of Nursing on Resident #22. The discharge plan that was initiated remains appropriate. 1. Identification of other residents having the potential to be affected was accomplished by: The Director of Nursing audited all discharges for the last 12 months, and one additional resident was noted to not have a proper discharge summary. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 5 muscles which release proteins and electrolytes into the blood stream and can cause death) R22's progress note on 9/8/21 identified R22 was discharged from the facility with the power of attorney (POA) and transferred to a senior living in another city. Discharge was initiated by the POA. Upon leaving the POA was sent with paper copy of discharge orders, medications, and referral to wound clinic. R22's medical record lacked a discharge summary and did not have a recapitulation of stay identifying the following: customary routine, cognitive patterns, communication, psychosocial well-being, physical functioning and structural problems, continence, disease diagnoses and health conditions, skin condition, activity level, special treatments and reconciliation of all pre-discharge medications with the resident's post-discharge medications. During interview on 10/28/2, at 10:23 a.m. the resident care coordinator (RCC) stated there was not a discharge summary or a recapitulation of stay done for R22. During interview on 10/28/21, at 10:28 a.m. the administrator stated when a R22 was discharged the nurse who discharged them should have insured a discharge summary and recapitulation of stay was done and placed in the chart or progress notes. When interviewed on 10/28/21, at 10:44 the director of nursing (DON) stated there were orders sent to the receiving facility and a referral for wound care, but a recapitulation of stay was not completed.	F 661	discharge summary was completed on 11/30/2021 by the Director of Nursing. The Director of Nursing audited all discharge summaries for the past 12 months. (One additional resident was identified to not have an appropriate discharge summary. The Director of Nursing completed the discharge summary on 11/30/2021 and placement remains appropriate. 2. Actions taken/systems put into place to reduce the risk of future occurrence include: On 11/15/2021 the Director of Nursing Services (DON) and the facility Social Services Designee provided in-service education programs for supervisory and assessment staff regarding the assessment and development of plans to address the residents discharge needs. The policy was revised to include the following in the discharge summary going forward: Identification of demographic information, customary routine, cognitive patterns, communication, vision, mood and behavior patterns, psychosocial well being, physical function continence, disease diagnoses, dental and nutritional status, skin conditions and activity pursuit. The Director of Nursing will monitor all discharges for the next four week to ensure the appropriate discharge summary is charted and sent to the receiving facility. This plan of correction will be monitored at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 661	Continued From page 6 The facility's Discharge Summary and Plan of Care policy dated 3/9/21, identified a discharge summary would be provided to the receiving facility and would include an overview of the resident's stay that included diagnoses, course of illness/treatment or therapy, radiology, pertinent labs, consultation results and a reconciliation of all pre-discharge medications with the resident's post discharge medications.	F 661	the every other month at the Quality Assurance meeting until such time consistent substantial compliance has been met.	
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess behaviors and implement person centered dementia interventions to minimize verbal and physical resident to resident altercations for 1 of 1 resident (R122) who was identified to have verbal and physical altercations with staff and residents. Finding include: R122's admission Minimum Data Set (MDS) dated 9/8/21, identified R122 had severe cognitive impairment and was independent with walking. R122 had verbal and physical behaviors directed towards other 1 to 3 days, other behaviors not directed at others 1 to 3 days, refusal of cares 1 to 3 days and wandering 4 to 6 days and would intrude on others privacy during a	F 744	1. Immediate action(s) taken for the resident(s) found to have been affected include: On 11/15/2021 R1 was comprehensively assessed and the care plan was updated to include specific behavioral triggers and interventions as related to dementia. Some of the triggers include a goal of resident will remain safe and redirectable when entering other persons rooms. Approaches: My room was moved to the opposite side of the Care Center for my safety, The Care Coordinator will contact my psychiatric providers and provide them with an update regarding my current behaviors, when I start showing signs and symptoms of aggression as evidence by yelling at others stating lets go, I may be	12/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 7 7-day period. Diagnoses include Alzheimer's disease, anxiety disorder and dementia with behavioral disturbance. R122's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 9/15/21, identified R122 exhibited behaviors of physical behaviors towards others, verbal behaviors towards others, behaviors not directed towards others, rejection of care, and wandering. R122 had a diagnosis of dementia w/behavioral disturbances with aggressive behavior, and wandering. Staff attempt to redirect mood/ behaviors with 1:1, nursing interventions, activities, toileting, and snacks. Care plan would include cognitive loss, and target behaviors. R122's Behavioral Symptoms CAA dated 9/15/21, identified behaviors increased in the evening or night. Behaviors included wandering and a presence of physical and verbal behaviors. R122's power of attorney (POA) identified the same behaviors at home. The CAA lacked specific interventions for R122 to minimize wandering and physical and verbal behaviors. R122's care plan reviewed 10/27/21, identified the following behavioral interventions: -wander guard to alert staff when he was exiting his room. -initiate 1:1 when resident was increasingly agitated. -when I begin to resist care, stop and reapproach later and do not force the task -try non-pharmacological interventions prior to initiating medications. The care plan lacked direction on how R1 displayed agitation or what non-pharmalogical interventions to try prior to admnistrering	F 744	cold and want a warm blanket provided by staff to meet my needs, When I start showing signs and symptoms of aggression as evidenced by yelling at other stating "let's go", I will have immediate increased supervision up to a 1:1 as needed for safety, when non-pharmacological interventions such as a warm blanket, 1:1 supervision, redirection are not successful. I may need a PRN medication to help keep me safe and relaxed along with the non-pharmacological interventions. Staff are provided with interventions on their daily care sheet for dementia related behaviors for residents. Care sheets are updated as resident needs and interventions change. 2. Identification of other residents having the potential to be affected was accomplished by: The Director of Nursing or designee has assessed all residents with dementia and care plans updated to ensure appropriate intervention. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: On 11/15/2021 the Director of Nursing Services (DON) and the Administrator provided in-service education programs on how to locate behavioral interventions on care sheets and how to initiate interventions for each specific resident. A dementia specific policy was created. Some of the highlighted areas include:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 8 mediations. The undated nursing assistant care (NA) sheet did not identifiy any behaviors or interventions for R122. R122's progress note identified the following: On 10/18/21, resident was discharged from a geriatric behavioral health facility and identified a possible trigger for behavior regarding how R122 would receive medications. During interview on 10/28/21, at 8:52 a.m. (NA)-E stated R122 would become agitated and aggressive and would strike out at staff and residents and the staff would just have to react to and interviene. Target behaviors or non-pharmacological interventions for R122 were not listed and only passed on in report between shifts. The NA care sheet identified resident needs for cares but did not address their behaviors or interventions to use. During interview on 10/27/21, at 2:23 p.m. NA-F stated R122 would routinely become aggressive towards other resident and staff, and it would happen more on the evening shift because of sundowning (a state of confusion occurring in the late afternoon and spanning into the night. It can cause a variety of behaviors, such as confusion, anxiety, aggression or ignoring directions and can also lead to pacing or wandering). When working with R122 they would not try to push him to do something he did not want to do, otherwise he would become agressive. The NA care sheet did not address behaviors or interventions and staff would have rely on report from the previous shift. When interviewed on 10/27/21 at 5:52 p.m.	F 744	• The facility will assess, develop, and implement care plans through an interdisciplinary team (IDT) approach that includes the resident, their family, and/or resident representative, to the extent possible. • The care plan goals will be achievable and the facility will provide resources necessary for the resident to be successful in meeting their goals. • The care plan interventions will be related to each resident's individual symptomology and rate of dementia (or related disease) progression with the end result being noted improvement or maintained of the expected stable rate of decline associated with dementia and dementia-like illnesses 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing or designee will complete random audits of 3 residents for 4 consecutive weeks to ensure they have been properly assessed by the MDS Coordinator for dementia related symptoms and behaviors and that proper interventions have been placed on the care plan. The Director of Nursing or designee will also audit care sheets to ensure the dementia specific interventions have been updated. This plan of correction will be monitored at the every other month at the Quality Assurance meeting until such time consistent substantial compliance has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 9 activities aide (AA)-A stated R122 was aggressive toward staff and residents. Recently R122 was hospitalized for his behaviors and aggression. The staff were unsure of any new interventions or changes to help R122's behaviors. Any changes for care would be found on the NA care sheet but the sheet did not address behaviors or interventions. During interview on 10/28/21, at 11:40 a.m. the director of nursing (DON) stated R122 had some interventions in place on the care plan like 1:1's when agitated and a wander guard to alert staff when he was leaving the room. Some of R122's triggers were being re-approached many times after refusing cares and redirection. R122 was a police officer for 31 years and would feel like he would need to sit behind the desk in the nurse's station and did not like to be told no. A tell when R122 was becoming more agitated was when he started to boss staff or residents around and he should be quietly redirected at that time. R122's target behaviors, triggers and interventions were not listed out completely in the care plan and they were not identified in the NA care sheets. The specific triggers and interventions should be documented for a safer and more dignified experience for all the residents in the facility. A policy for dementia care was requested, but not received.	F 744		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 755		12/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 10 §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to appropriately transcribe verbal/telephone physician orders for 1 of 5 residents (R1) reviewed for medications. Findings include: R1's quarterly Minimum Data Set (MDS) dated 9/29/21, identified R1 had diagnoses that included type II diabetes.	F 755	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 11 R1's Physician Order Report dated 9/7/21, included an order for Tresiba (a long-acting insulin used to control high blood sugar in adults with diabetes) Flextouch pen 200 unit/milliliter (mL) 60 units subcutaneously once every morning. Next to the order, a handwritten notation indicated to increase the Tresiba to 75 units. The orders were signed by R1's primary care physician on 9/7/21. R1's electronic medication administration record (eMAR) indicated R1 had received Tresiba Flextouch pen 200 unit/mL 74 units 9/8/21, to present. The medical record lacked any telephone communication with a practitioner identifying an order for the dosage change of the Tresiba. R1's nursing progress note dated 9/8/21, identified the writer received notification to change R1's order for "Lantus" (a long acting insulin) from 75 units to 74 units from R1's physician's nurse via phone. R1's Tresiba Flextouch pharmacy label dated 10/15/21, directed staff to inject 75 units subcutaneously once daily in the morning. During interview on 10/26/21, at 3:49 p.m. licensed practical nurse (LPN)-B stated orders were entered depending on how the order was received (i.e...physician rounds, telephone orders or faxed communication). When the physician was back at the facility for rounds, he would sign all orders. LPN-B reviewed R1's orders and stated the order for Tresiba was changed on 9/8/21, to 74 units and she was unsure why this happened. "Maybe they had to call and clarify the order". There was no documentation explaining why this occurred because the nursing progress	F 755	1. Immediate action(s) taken for the resident(s) found to have been affected include: R1s Tresiba order was confirmed to be 76 units and was countersigned by the residents PCP within 48 hours. 2. Identification of other residents having the potential to be affected was accomplished by: The residents that are on insulin have been identified as to have the potential to be affected. The Director of Nursing has audited the potential residents residing in the facility and has concluded that the verbal orders taken were signed by the primary care provider per policy and procedure. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: On 11/15/2021 the Director of Nursing Services (DON) provided an in-service education programs for licensed nursing staff regarding the assessment and development of plans to address telephone and verbal orders. The policy was revised to include the following: -Repeat any prescribed orders back to the physician or health care provider. -Use clarification questions to avoid misunderstandings. -Enter the order into the medical record manually or electronically. -Write T.O. (telephone order) or V.O. (verbal order), including date, time, name of the resident, the complete order; and sign the name of the physician or health	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 12 note dated 9/8/21, indicated "Lantus was increased to 74 units" not Tresiba. LPN-B stated the facility had no specific form to track telephone orders. A nurse would simply enter a nursing progress note and enter the order into the computer and the physician would not countersign the order until his next rounding at the facility. During interview on 10/26/21, at 4:00 p.m. the director of nursing (DON) stated R1's Tresiba order was changed after nursing staff clarified with the physician because the medication could only be administered in "even" doses; 74 or 76 for example. Upon review of R1's nursing progress notes and physician orders, the DON stated registered nurse (RN)-B entered the order change of Tresiba to 74 units on 9/8/21, and "must have" had a conversation on the phone or during rounding with the physician. The facility had a process to complete a telephone order that included: writing down the order on a piece of paper, repeating the order back to the physician to clarify exactly what was directed, writing a nursing progress note, and the order was entered into the resident's eMAR. - The DON did not find a nursing progress note that addressed R1's Tresiba dated 9/8/21, nor did the chart reflect any other documentation of a telephone order for Tresiba on that date. Upon review of R1's Tresiba Flextouch pen pharmacy label, the label stated 75 units subcutaneously every morning. At that time, the DON stated the facility utilized a program for "standard works" for processes such as telephone orders and "clearly" the facility needed to create a standard works for telephone order to ensure documentation and orders were entered accordingly.	F 755	care provider and nurse or sign off the electronic order as per the software system guidelines. -The physician should sign the order on his/her next visit to the facility or within the time frame required by the facility. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services will audit the next rounding date. The Director of Nursing or designee will audit 2 additional residents per week for the next four weeks to ensure verbal orders have been properly transcribing and signed by the physician on the next visit. This plan of correction will be monitored at the every other month at the Quality Assurance meeting until such time consistent substantial compliance has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 13	F 755		

During interview on 10/26/21, at 4:27 p.m. RN-B stated the morning of 9/8/21 a LPN reported Tresiba could only be administered in amounts of 2 units so she called and obtained a telephone order to change R1's Tresiba to 74 unit subcutaneously every day. She entered the order into R1's electronic medical record along with a nursing progress note. Upon review of R1's nursing progress note, RN-B stated she had corrected the nursing progress note after she was notified of a typo a few minutes prior. RN-B stated she had entered Lantus, but the order was for Tresiba. It was a transcription error, but she corrected it.

During a phone interview on 10/28/21, at 2:32 p.m. the pharmacist stated the pharmacy's most recent order for R1's Tresiba was for 75 units subcutaneously every morning which was received on 10/15/21. The pharmacy received no notification from the facility or the physician of R1's dose change and the pharmacist would have expected a call or fax from the facility regarding this. Additionally, Tresiba could be dosed in increments of 1 unit.

The facility policy Verbal Telephone Orders dated 4/29/21, identified the procedure for verification of verbal orders included:
a. Immediately write down as they are received.
b. Then read back the orders to the issuing practitioner for verification/confirmation before the patient intervention begins. The read back should be done without the use of abbreviations.
c. Document orders on the appropriate record or enter them into the computer as they are received. If immediate documentation is not possible due to an emergent situation, the orders

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 14 will be immediately repeated to the issuing practitioner and then written immediately after the situation is controlled. d. In code situations, a repeat back of the order is acceptable to the physician before administering the medication or treatment. In such cases, the code recorder documents the name of the drug, dose, time, route and rate. e. Each verbal/telephone order will be followed up with a written physician order. The individual receiving the order must document from whom the orders were issued, and the practitioner's title, date, time and type of order (verbal or telephone), and then sign the order, VORB (verbal order read back), the receiving individual's complete name, title, time and date. The policy further identified the orders were to be visually verified by the ordering practitioner and countersigned within 48 hours.	F 755		
F 880 SS=F	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 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	F 880		12/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 15 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 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.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 16 §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 interview and document review the facility failed to track, trend and analyze all actual and potential infections to prevent the spread of communicable disease. In addition, the facility failed to ensure 2 of 2 staff(RN-A, LPN-A) utitilized eye protection as directed by the Centers for Disease Control (CDC) while in resident care areas with the potential to affect all 22 residents who resided in the facility; failed to ensure residents hands were cleansed in a manner to prevent cross contamination for 7 of 7 residents (R1, R2, R9, R10, R11, R13, and R122) observed during dining; and the facility failed to ensure total mechanical lift equipment was disinfected after every use for 2 of 2 residents (R4, R8) observed to use a mechanical lift. These deficient practices had the potential to affect all 22 residents who resided in the facility. Findings include: TRACKING, TRENDING and ANALYSIS: The untitled facility spreadsheet from August to October 2021, tracked actual infections and antibiotic use. The information collected included resident name, room number, exiting infection from a previous month, infection type, body	F 880	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Eye Protection: " Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Staff are provided eye protection upon entering the facility and are expected to wear them at all times while on unit. Staff have been provided education on the use of eye protection, how to don and doff eye protection, how to clean their eye protection and store it. Staff have been given a skills competency check off on donning and doffing eye protection and how to store their eye protection. The facility has developed a policy specific to the donning and doffing of eye protection.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 17 system of infection, surveillance definitions, symptoms, onset date, device type, date of insertion, date of removal, device days, infection risk factors, diagnostic test, test date, type of test, specimen source, results (organism colony counts for urine), antibiotic resistant organism, antibiotic name, class, dose, route, frequency, provider and where the medication was prescribed (facility, emergency department, hospital or other) and identified the following: - August 2021: identified the following infections: five pneumonia, a urinary tract infection and three unidentified infections. Two of the pneumonia cases were identified twice because the resident was prescribed two antibiotics on the same date. The facility tracking form did not identify actual/ potential infections that were not treated with antibiotics. A map of the facility was included with the form; however, only four infections were marked on the map and a handwritten note indicated "no trends noted". In addition, the facility form Infection Control Log dated August 2021, tracked actual infections and antibiotic use. The information collected included resident name, date, room number, symptoms (specific), nursing interventions, and diagnosis that would contribute. The form identified five residents that required treatment with antibiotics during August 2021; however, the residents listed on the form did not correlate with the untitled spreadsheet. - September 2021: identified the following infections: three urinary tract infections and one prophylaxis for facial surgery. One of the urinary tract infections was listed twice because two antibiotics were prescribed on the same date. A map of the facility was included with the form.; however, only two infections were identified and a	F 880	Residents and their representatives will receive education on the use of appropriate use of face masks when in the facility. " Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits of donning/doffing PPE with Transmission Based Precautions i.e. Droplet precautions. The Director of Nursing, Infection Preventionist, and other facility leadership will conduct routine audits on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Audits should continue until 100% compliance is met on source control masking for staff, visitors, and residents. The Director of Nursing, Infection Preventionist, and other facility leadership will conduct real time audits on all aerosolized generating procedures to ensure PPE is in us. The Director of Nursing, Infection Preventionist, and other facility leadership will conduct real time audits on proper use of gowns to ensure PPE is in use. The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 18 handwritten note indicated "no trends noted". The facility form Infection Control Log dated August 2021, additionally tracked actual infections and antibiotic use. The information collected included resident name, date, room number, symptoms (specific), nursing interventions, and diagnosis that would contribute. The form identified two residents that required treatment with antibiotics during September 2021; however, the residents listed on the form did not include one resident listed on the untitled spreadsheet. - October 2021: identified the following infections: five urinary tract infections, one pneumonia, one cellulitis/soft tissue/wound infection and one unidentified infection. A map of the facility was included with the form; however, only three infections were identified. The facility form Infection Control Log dated August 2021 additionally tracked actual infections and antibiotic use. The information collected included resident name, date, room number, symptoms (specific), nursing interventions, and diagnosis that would contribute. The form identified five residents that required treatment with antibiotics during October 2021; however, the residents listed on the form did not include one resident listed on the untitled spreadsheet. During interview on 10/27/21 at 10:44 a.m. director of nursing (DON) stated she used a program in the electronic medical record for infection tracking, but also utilized a spreadsheet because the program was still in trial use. The program allowed the floor nurses to make entries into the infection control log and the DON would only need to supervise it's use. The facility had a process for the floor nurses to make an entry into the infection control tracking program whenever	F 880	Quality Assurance Program Improvement (QAPI) program Hand Washing: " Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Residents hands will be washed before and after meals and as needed with disposable purell hand sanitizing wipes. Wipes were ordered and arrived at the facility and are being used at meal times and as needed between meals for residents who are unable to use soap and water. Hand washing policies have been modified to include resident hand hygiene. " Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this deficient practice. Staff will demonstrate competency and handwashing for both themselves and for washing resident hands. " The Director of Nursing, the Infection Preventionist and/or other facility leadership will conduct audits on all shifts, every day for one week, then may decrease the frequency based upon compliance. Audits should continue until 100% compliance is met. Tracking and Trending: " Address how corrective action will be accomplished for those residents found to have been affected by the deficient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 19 an antibiotic, antimicrobial or antifungal was prescribed. Whenever a potential infection was identified, the nurse would assess the resident then contact the physician for a prescription order. A nursing progress note would be documented and a nursing order would be entered to monitor the infection daily. If the physician did not order a medication, no entry would be documented in the infection control program. At that time, the DON provided a handwritten log titled Infection Control Log from August to October 2021; however, the DON stated all entries were for antibiotics as well and any resident that did not require a medication such as a cough, fever, or viral infection would not be tracked. During interview on 10/28/21, at 8:36 a.m. the administrator stated she spoke with the DON and was aware of the concerns with the tracking, trending and analysis of facility infections and the facility needed to do an "overhaul" of the infection surveillance program. A facility policy regarding infection tracking, trending and analysis was requested, but not received. PERSONAL PROTECTIVE EQUIPMENT (PPE): On 10/25/21, at 2:33 p.m. registered nurse (RN)-A was observed sitting at the nurses desk. She was wearing a surgical mask; however, her goggles were resting on the top of her head. Staff were coming in and out of the nurses' station and residents were gathered around the area and in the tv room. RN-A did not attempt to position her goggles correctly. RN-A stated goggles were required for direct resident care and were not	F 880	practice. The facility□s QAPI committee will complete a root cause analysis to identify the problems that resulted in the deficiency. The root cause analysis identified that lack of staff education led to the miss in tracking and trending resident symptoms. An on-site iCar assessment was completed with the Director of Nursing, Infection Prevention Nurse and Administrator on 11/30/2021 where education was provided on tracking all symptoms for residents and employees. Education has been provided to charge nurse□s on the location of the facility wide spreadsheet for tracking and trending symptoms. This will be monitored daily by the charge nurses, infection prevention nurse of Director of Nursing. " Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The Infection Prevention nurse and/or Director of Nursing will investigate any potential outbreaks and follow up as appropriate. Any unexpected increases in infection must be reported to the Medical Director, and/or Public Health Department, and the state survey agency in our to obtain guidance for infection control concerns. Washing of Hoyers: " Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The QAPI committee met on 12/01/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 20 required when she was in her office. RN-A stated she forgot to put the goggles back on when she left her office. On 10/25/21, at 2:40 p.m. licensed practical nurse (LPN)-A stated she had worked at the facility for approximately one month, but worked on the floor maybe five to six times. LPN-A was wearing her normal prescription eyeglasses without a faceshield or goggles. LPN-A stated she did not normally do that and wore slip on side shields on her glasses, but had forgotten them at home that day. LPN-A stated "I'm sorry", but continued to go without eye protection for the rest of her shift. RN-A, the administrator nor the director of nursing (DON) redirected LPN-A to wear eye protection. During interview on 10/27/21, at 11:09 a.m. the DON stated she was unaware any staff member used slip on side guards which were unapproved eye protection. All staff were expected to correctly wear approved eye protection to prevent the spread or transmission of COVID-19. During interview on 10/28/21, at 8:36 a.m. the administrator stated she was aware of staff not wearing eye protection correctly or wearing slip on side guards; however, was unaware of staff not wearing eye protection at all. The slip on side guards were unapproved eye protection, but the facility supplied all staff with goggles and all staff were expected to wear eye protection according to CDC guidance. The facility policy Care Center PPE dated 3/9/21, indicated the purpose of PPE was to protect staff or residents from possible exposure to different pathogens. Further, staff were directed to wear	F 880	to complete a root cause analysis regarding washing of resident equipment. The root cause of the deficiency is found to be in regards to staff education. A policy was modified to include the types of sanitizing will be used on resident equipment, when equipment will be sanitized and contact times. Staff have been given a skills competency check-off on disinfection of resident equipment. Audits will be conducted to ensure staff are completing the proper disinfection and are proven competent. " Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The Director of Nursing, the Infection Preventionist, and/or other facility leadership will conduct audits for proper cleaning and disinfection of resident use equipment/environmental cleaning, on all shifts every day for one week, then may decrease frequency as determined by compliance. This plan of correction will be monitored at the every other month at the Quality Assurance meeting until such time consistent substantial compliance has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 21	F 880		

goggles or a face shield as added face/eye protection. Personal glasses were not a substitute for goggles.

The Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes updated 9/10/21, healthcare personal (HCP) caring for residents with suspected or confirmed SARS-CoV-2 infection should use full PPE (gowns, gloves, eye protection ((goggles or a face shield that covers the front and sides of the face), and a NIOSH-approved N95 or equivalent or higher-level respirator).

HAND HYGIENE:

During a dining observation on 10/25/21, at 5:35 p.m. residents were assisted to the dining room for their supper meals. The DON brought a cart around the room with a basin of warm soapy water, a stack of washcloths and a stack of hand towels. The DON applied gloves, placed a washcloth in the basin and wrung the washcloth out with both hands. From 5:42 p.m. until 5:46 p.m. the DON proceeded to approach each resident (R1, R2, R9, R10, R11, R13, and R122) to encourage them to wash their hands prior to their meal; however, the DON proceeded to go back into the basin of water with soiled gloves; contaminated water and moved on to the next resident, without changing water or completing self hand hygiene. After the last resident was assisted to wash their hands the DON removed her gloves, but did not perform hand hygiene.

During interview on 10/25/21, at 5:53 p.m. the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 22	F 880		

DON stated she was aware she had not changed gloves between residents when she assisted them to wash their hands prior to their meal. She attempted to touch the residents with her left hand only in order to leave her right hand clean; however, realized she went back into the water basin with both hands thus contaminated the water. "Ideally, I should have changed gloves after every resident" and the water was contaminated. At that time, the DON directed staff to use hand sanitizer wipes for all residents.

A facility hand hygiene policy was requested but not received.

EQUIPMENT:

R4's quarterly minimum data set (MDS) dated 9/22/21, indicated R4 was totally dependent on staff for transfers and did not ambulate.

R4's medical record lacked evidence R4 had any signs or symptoms of COVID-19.

R8's significant change MDS dated 8/31/21, indicated R8 required extensive assistance with transfers, was totally dependent on staff for locomotion and did not ambulate.

R8's medical record lacked evidence R6 had any signs or symptoms of COVID-19.

On 10/25/21, at 3:35 p.m. registered nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 23	F 880		

(RN)-A and nursing assistant (NA)-B were transferring R4 into the wheelchair with a total mechanical lift. Upon exiting R4's room NA-B was not observed to disinfect the lift. NA-B stated she had not disinfected the lift with disinfecting wipes and did not know how often the lifts should be disinfected.

During interview on 10/25/21, at 3:43 p.m. NA-C stated she did not disinfect the total mechanical lifts after each use and was uncertain how often the lifts were to be disinfected.

- At 3:45 p.m. RN-A stated there was a sign attached to the total mechanical lift lifts which directed staff to disinfect it after each use.

During observation on 10/26/21, at 1:02 p.m. trained medication aide (TMA)-A and NA-D transferred R6 from the wheelchair to a recliner using the total mechanical lift. Without disinfecting the lift, TMA-A and NA-D then wheeled the same lift into R4's room and transferred R4 from the bed to the wheelchair. Neither TMA-A or NA-D disinfected the total mechanical lift after transferring R6 or prior to transferring R4.

During interview on 10/26/21, at 1:12 p.m. activities aide (AA)-A stated the total mechanical lift lifts should be disinfected after every use.

- At 1:18 p.m. TMA-A and NA-D stated they did not disinfect the total mechanical lift after transferring R6 and prior to transferring R4. Both TMA-A and NA-D stated they were supposed to disinfect the total mechanical lifts after every use.

During interview on 10/28/21, at 11:43 a.m. the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 24 administrator stated the total mechanical lifts should be disinfected and staff were expected to disinfect the lifts between each use. Staff were aware of the policy which was in place since the start of the COVID-19 pandemic. The facilities Disinfecting and Disinfecting of Resident Equipment policy revised 3/9/21, identified reusable multiple-resident items as items that could be used multiple times for multiple residents and that could be a source of indirect transmission of pathogens. The policy further directed staff to clean and disinfect reusable multiple-resident items in accordance with current CDC recommendations in order to break the chain of infection.	F 880		
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or	F 886		12/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 25 suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 26 efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure facility testing tracking for residents who exhibited symptoms of COVID-19 and received a negative antigen test included evidence a confirmatory PCR (polymerase chain reaction test) was completed to rule out COVID-19. This had the potential to affect all 22 residents who resided in the facility. Findings include: The facility form Weekly Monitoring for Resident COVID-19 Symptoms dated 10/11/21 to 10/25/21, identified five residents exhibited COVID-19 symptoms during that timeframe. Symptoms included transmission based precautions (although not a symptom), fever, diarrhea and low oxygen saturations. The form lacked information such as testing status, test results or steps taken to prevent the spread of COVID-19. During interview on 10/26/21, at 1:28 p.m. the director of nursing (DON) stated data was collected daily, weekly and monthly looking for trends in infections. All residents were fully vaccinated against COVID-19 and each resident was monitored for symptoms daily. When a resident was symptomatic they would increase monitoring, place into transmission based precautions, and obtain a rapid antigen test. If the antigen test was negative, nursing staff would increase monitoring and, if positive, the resident would be placed immediately into the COVID unit. After this, it would depend on the resident's symptoms if a confirmatory PCR was collected.	F 886	1. Immediate action(s) taken for the resident(s) found to have been affected include: Any resident experiencing one or more symptom of COVID-19 will be immediately given a PCR test to rule out or confirm a case of COVID-19. Staff will be able to reference the COVID-19 binder for symptoms of COVID-19. Policy was reviewed and revised for accuracy and now includes the indication of a PCR test to be completed on resident(s). 2. Identification of other residents having the potential to be affected was accomplished by: Staff will reference the COVID-19 symptom list to determine if a resident is experiencing a symptom of COVID-19 and warrants a PCR test during their shift. The Director of Nursing of designee has audited the medical record of all residents dating back 60 days. No additional findings that would have warranted a PCR test was identified 3. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service education program was conducted by the Director of Nursing Services with staff nurses on 11/15/2021 addressing the facility policy regarding testing of residents with symptoms of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 27 For example, if the resident's symptoms worsened a confirmatory test was done. During interview on 10/27/21, at 9:31 a.m. the DON stated when she went through the log she realized she needed to mark down symptoms that were outside of the normal for the resident. "I guess I was doing overkill." However, there were residents listed on the form that were truly symptomatic and were never tested and some only had an antigen test and did not have a confirmatory PCR. The DON stated she expected staff to obtain an antigen test for any symptomatic resident and to contact the resident's physician for a confirmatory PCR for any negative antigen results. During interview on 10/28/21, at 8:10 a.m. the administrator stated all residents were fully vaccinated against COVID-19 and they had not had a resident case since December of 2020, but had recently had a positive COVID-19 employee. Polk County transmission rate had been high since 9/9/21 and the facility had increased staff testing at that time for unvaccinated staff, but had begun outbreak testing on 10/20/21. For testing, the facility was utilizing BinaxNOW tests which were antigen tests and if any staff returned positive a PCR was collected to confirm the result. The DON then stated anyone exhibiting symptoms should have a PCR to verify they do not have COVID-19. The facility policy COVID-19 testing dated 9/23/21, identified testing was a priority to help inform clinical care and infection prevention and control practices in their setting. The policy directed to test all residents if symptomatic: fever, shortness of breath, new or change in cough,	F 886	COVID-19. Staff were educated on what symptoms would trigger a PCR test. Staff can reference the list of COVID-19 symptoms at the nurses station, and if a resident is experiencing one or more symptoms they are to be given a PCR test. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing or Infection Prevention Nurse will audit the symptom tracking five times per week for four weeks to ensure any resident warranting a COVID-19 PCR is given one. This plan of correction will be monitored at the every other month at the Quality Assurance meeting until such time consistent substantial compliance has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 28 chills, sore throat, muscle aches, new or worsening malaise, headaches, new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, new confusion/altered mental status, or new/worsening hypoxia. The policy further indicated R-PCR-based testing could inform clinical decision making; however, the policy did address the use of antigen testing. The Centers for Disease Control and Prevention (CDC) guidance SARS CoV-2 Antigen Testing in Long Term Care Facilities dated 1/7/21, identified symptomatic people who test antigen negative should have a confirmatory test performed. Confirmatory test should be performed with nucleic acid amplifications tests (NAAT) such as reverse transcriptase polymerase chain reaction (RT-PCR). As the sensitivity of antigen tests is generally lower than RT-PCR, negative point of care antigen tests should be considered presumptive. Testing of symptomatic residents or healthcare personal (HCP). -If an antigen test is presumptive negative, perform NAAT immediately (e.g., within 2 days). -Symptomatic residents should be kept on transmission-based precautions until NAAT results return. -If a confirmatory NAAT is performed within 2 days, people should be assumed to be infectious until the confirmatory test results are completed. For instance, in general, if a symptomatic resident tests presumptive negative by antigen test and a NAAT is performed, the resident should remain in Transmission-Based Precautions until the NAAT result is available.	F 886		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 23, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: 598J11

Dear Administrator:

The above facility was surveyed on October 25, 2021 through October 28, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
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
	00470	A. BUILDING: _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/25/21 through 10/28/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were found to be SUBSTANTIATED: H5251042C (MN77830); however, no licensing orders were issued Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 665	MN Rule 4658.0455 B Telephone and Electronic Orders B. Orders received by telephone or other electronic means, not including facsimile machine, must be immediately recorded or placed in the resident's record by the person authorized by the nursing home and must be countersigned by the ordering health care practitioner authorized to prescribe at the time of the next visit, or within 60 days, whichever is sooner. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to appropriately transcribe verbal/telephone physician orders for 1 of 5 residents (R1) reviewed for medications. Findings include: R1's quarterly Minimum Data Set (MDS) dated 9/29/21, identified R1 had diagnoses that included type II diabetes. R1's Physician Order Report dated 9/7/21, included an order for Tresiba (a long-acting insulin used to control high blood sugar in adults	2 665	Corrected	12/20/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 665	Continued From page 3	2 665		

with diabetes) Flextouch pen 200 unit/milliliter (mL) 60 units subcutaneously once every morning. Next to the order, a handwritten notation indicated to increase the Tresiba to 75 units. The orders were signed by R1's primary care physician on 9/7/21. R1's electronic medication administration record (eMAR) indicated R1 had received Tresiba Flextouch pen 200 unit/mL 74 units 9/8/21, to present. The medical record lacked any telephone communication with a practitioner identifying an order for the dosage change of the Tresiba.

R1's nursing progress note dated 9/8/21, identified the writer received notification to change R1's order for "Lantus" (a long acting insulin) from 75 units to 74 units from R1's physician's nurse via phone.

R1's Tresiba Flextouch pharmacy label dated 10/15/21, directed staff to inject 75 units subcutaneously once daily in the morning.

During interview on 10/26/21, at 3:49 p.m. licensed practical nurse (LPN)-B stated orders were entered depending on how the order was received (i.e...physician rounds, telephone orders or faxed communication). When the physician was back at the facility for rounds, he would sign all orders. LPN-B reviewed R1's orders and stated the order for Tresiba was changed on 9/8/21, to 74 units and she was unsure why this happened. "Maybe they had to call and clarify the order". There was no documentation explaining why this occurred because the nursing progress note dated 9/8/21, indicated "Lantus was increased to 74 units" not Tresiba. LPN-B stated the facility had no specific form to track telephone orders. A nurse would simply enter a nursing progress note and enter the order into the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 665	Continued From page 4	2 665		

computer and the physician would not countersign the order until his next rounding at the facility.

During interview on 10/26/21, at 4:00 p.m. the director of nursing (DON) stated R1's Tresiba order was changed after nursing staff clarified with the physician because the medication could only be administered in "even" doses; 74 or 76 for example. Upon review of R1's nursing progress notes and physician orders, the DON stated registered nurse (RN)-B entered the order change of Tresiba to 74 units on 9/8/21, and "must have" had a conversation on the phone or during rounding with the physician. The facility had a process to complete a telephone order that included: writing down the order on a piece of paper, repeating the order back to the physician to clarify exactly what was directed, writing a nursing progress note, and the order was entered into the resident's eMAR.

- The DON did not find a nursing progress note that addressed R1's Tresiba dated 9/8/21, nor did the chart reflect any other documentation of a telephone order for Tresiba on that date. Upon review of R1's Tresiba Flextouch pen pharmacy label, the label stated 75 units subcutaneously every morning. At that time, the DON stated the facility utilized a program for "standard works" for processes such as telephone orders and "clearly" the facility needed to create a standard works for telephone order to ensure documentation and orders were entered accordingly.

During interview on 10/26/21, at 4:27 p.m. RN-B stated the morning of 9/8/21 a LPN reported Tresiba could only be administered in amounts of 2 units so she called and obtained a telephone order to change R1's Tresiba to 74 unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 665	Continued From page 5 subcutaneously every day. She entered the order into R1's electronic medical record along with a nursing progress note. Upon review of R1's nursing progress note, RN-B stated she had corrected the nursing progress note after she was notified of a typo a few minutes prior. RN-B stated she had entered Lantus, but the order was for Tresiba. It was a transcription error, but she corrected it. During a phone interview on 10/28/21, at 2:32 p.m. the pharmacist stated the pharmacy's most recent order for R1's Tresiba was for 75 units subcutaneously every morning which was received on 10/15/21. The pharmacy received no notification from the facility or the physician of R1's dose change and the pharmacist would have expected a call or fax from the facility regarding this. Additionally, Tresiba could be dosed in increments of 1 unit. The facility policy Verbal Telephone Orders dated 4/29/21, identified the procedure for verification of verbal orders included: a. Immediately write down as they are received. b. Then read back the orders to the issuing practitioner for verification/confirmation before the patient intervention begins. The read back should be done without the use of abbreviations. c. Document orders on the appropriate record or enter them into the computer as they are received. If immediate documentation is not possible due to an emergent situation, the orders will be immediately repeated to the issuing practitioner and then written immediately after the situation is controlled. d. In code situations, a repeat back of the order is acceptable to the physician before administering the medication or treatment. In such cases, the code recorder documents the name of the drug,	2 665		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 665	Continued From page 6 dose, time, route and rate. e. Each verbal/telephone order will be followed up with a written physician order. The individual receiving the order must document from whom the orders were issued, and the practitioner's title, date, time and type of order (verbal or telephone), and then sign the order, VORB (verbal order read back), the receiving individual's complete name, title, time and date. The policy further identified the orders were to be visually verified by the ordering practitioner and countersigned within 48 hours. SUGGESTED METHOD OF CORRECTION: The administrator, DON or designee could review /revise/ develop policy and procedures regarding receiving verbal/telephone orders and transcription of physician orders. The administrator, DON or designee could re-educate the nursing staff of receiving and transcription of physician orders, and could implement a monitoring system for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 665		
2 685	MN Rule 4658.0465 Subp. 2 Transfer, Discharge, and Death Subp. 2. Other discharge. When a resident is transferred or discharged for any reason other than death, the nursing home must compile a discharge summary that includes the date and time of transfer or discharge, reason for transfer or discharge, transfer or discharge diagnoses, and condition. This MN Requirement is not met as evidenced	2 685		12/20/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 685	Continued From page 7 by: Based on interview and document review, the facility failed to ensure a comprehensive discharge summary, including a recapitulation of stay was completed, and provided at the time of transfer to ensure continuity of care for 1 of 1 resident (R22) who was reviewed for discharge practices. Findings include: R22's admission Minimum Data Set (MDS) dated 9/1/21 identified severe cognitive impairment and was an extensive assist for dressing, toilet use and personal hygiene. R22's diagnoses included recent joint replacement surgery, dementia, epilepsy and rhabdomyolysis (a breakdown of muscles which release proteins and electrolytes into the blood stream and can cause death) R22's progress note on 9/8/21 identified R22 was discharged from the facility with the power of attorney (POA) and transferred to a senior living in another city. Discharge was initiated by the POA. Upon leaving the POA was sent with paper copy of discharge orders, medications, and referral to wound clinic. R22's medical record lacked a discharge summary and did not have a recapitulation of stay identifying the following: customary routine, cognitive patterns, communication, psychosocial well-being, physical functioning and structural problems, continence, disease diagnoses and health conditions, skin condition, activity level, special treatments and reconciliation of all pre-discharge medications with the resident's post-discharge medications. During interview on 10/28/2, at 10:23 a.m. the	2 685	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 685	Continued From page 8 resident care coordinator (RCC) stated there was not a discharge summary or a recapitulation of stay done for R22. During interview on 10/28/21, at 10:28 a.m. the administrator stated when a R22 was discharged the nurse who discharged them should have insured a discharge summary and recapitulation of stay was done and placed in the chart or progress notes. When interviewed on 10/28/21, at 10:44 the director of nursing (DON) stated there were orders sent to the receiving facility and a referral for wound care, but a recapitulation of stay was not completed. The facility's Discharge Summary and Plan of Care policy dated 3/9/21, identified a discharge summary would be provided to the receiving facility and would include an overview of the resident's stay that included diagnoses, course of illness/treatment or therapy, radiology, pertinent labs, consultation results and a reconciliation of all pre-discharge medications with the resident's post discharge medications. SUGGESTED METHODS OF CORRECTION: The administrator, DON or designee could develop, review, and /or revise policies and procedures to ensure recapitulations were completed for all discharged residents. The administrator, DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one	2 685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 685	Continued From page 9 (21) days.	2 685		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to track, trend and analyze all actual and potential infections to prevent the spread of	21390	Corrected	12/20/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 10	21390		

communicable disease. In addition, the facility failed to ensure 2 of 2 staff(RN-A, LPN-A) utitilized eye protection as directed by the Centers for Disease Control (CDC) while in resident care areas potential to affect all 22 residents who reside in the facility ; failed to ensure residents hands were cleansed in a manner to prevent cross contamination for 7 of 7 residents (R1, R2, R9, R10, R11, R13, and R122) observed during dining; and the facility failed to ensure total mechanical lift equipment was disinfected after every use for 2 of 2 residents (R4, R8) observed to use a mechanical lift. These deficient practices had the potential to affect all 22 residents who resided in the facility.

Findings include:

TRACKING, TRENDING and ANALYSIS:

The untitled facility spreadsheet from August to October 2021, tracked actual infections and antibiotic use. The information collected included resident name, room number, exiting infection from a previous month, infection type, body system of infection, surveillance definitions, symptoms, onset date, device type, date of insertion, date of removal, device days, infection risk factors, diagnostic test, test date, type of test, specimen source, results (organism colony counts for urine), antibiotic resistant organism, antibiotic name, class, dose, route, frequency, provider and where the medication was prescribed (facility, emergency department, hospital or other) and identified the following:

- August 2021: identified the following infections: five pneumonia, a urinary tract infection and three unidentified infections. Two of the pneumonia cases were identified twice because the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 11	21390		

was prescribed two antibiotics on the same date. The facility tracking form did not identify actual/ potential infections that were not treated with antibiotics. A map of the facility was included with the form; however, only four infections were marked on the map and a handwritten note indicated "no trends noted". In addition, the facility form Infection Control Log dated August 2021, tracked actual infections and antibiotic use. The information collected included resident name, date, room number, symptoms (specific), nursing interventions, and diagnosis that would contribute. The form identified five residents that required treatment with antibiotics during August 2021; however, the residents listed on the form did not correlate with the untitled spreadsheet.

- September 2021: identified the following infections: three urinary tract infections and one prophylaxis for facial surgery. One of the urinary tract infections was listed twice because two antibiotics were prescribed on the same date. A map of the facility was included with the form.; however, only two infections were identified and a handwritten note indicated "no trends noted". The facility form Infection Control Log dated August 2021, additionally tracked actual infections and antibiotic use. The information collected included resident name, date, room number, symptoms (specific), nursing interventions, and diagnosis that would contribute. The form identified two residents that required treatment with antibiotics during September 2021; however, the residents listed on the form did not include one resident listed on the untitled spreadsheet.

- October 2021: identified the following infections: five urinary tract infections, one pneumonia, one cellulitis/soft tissue/wound infection and one unidentified infection. A map of the facility was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 12 included with the form; however, only three infections were identified. The facility form Infection Control Log dated August 2021 additionally tracked actual infections and antibiotic use. The information collected included resident name, date, room number, symptoms (specific), nursing interventions, and diagnosis that would contribute. The form identified five residents that required treatment with antibiotics during October 2021; however, the residents listed on the form did not include one resident listed on the untitled spreadsheet. During interview on 10/27/21 at 10:44 a.m. director of nursing (DON) stated she used a program in the electronic medical record for infection tracking, but also utilized a spreadsheet because the program was still in trial use. The program allowed the floor nurses to make entries into the infection control log and the DON would only need to supervise it's use. The facility had a process for the floor nurses to make an entry into the infection control tracking program whenever an antibiotic, antimicrobial or antifungal was prescribed. Whenever a potential infection was identified, the nurse would assess the resident then contact the physician for a prescription order. A nursing progress note would be documented and a nursing order would be entered to monitor the infection daily. If the physician did not order a medication, no entry would be documented in the infection control program. At that time, the DON provided a handwritten log titled Infection Control Log from August to October 2021; however, the DON stated all entries were for antibiotics as well and any resident that did not require a medication such as a cough, fever, or viral infection would not be tracked.	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 13 During interview on 10/28/21, at 8:36 a.m. the administrator stated she spoke with the DON and was aware of the concerns with the tracking, trending and analysis of facility infections and the facility needed to do an "overhaul" of the infection surveillance program. A facility policy regarding infection tracking, trending and analysis was requested, but not received. PERSONAL PROTECTIVE EQUIPMENT (PPE): On 10/25/21, at 2:33 p.m. registered nurse (RN)-A was observed sitting at the nurses desk. She was wearing a surgical mask; however, her goggles were resting on the top of her head. Staff were coming in and out of the nurses' station and residents were gathered around the area and in the tv room. RN-A did not attempt to position her goggles correctly. RN-A stated goggles were required for direct resident care and were not required when she was in her office. RN-A stated she forgot to put the goggles back on when she left her office. On 10/25/21, at 2:40 p.m. licensed practical nurse (LPN)-A stated she had worked at the facility for approximately one month, but worked on the floor maybe five to six times. LPN-A was wearing her normal prescription eyeglasses without a faceshield or goggles. LPN-A stated she did not normally do that and wore slip on side shields on her glasses, but had forgotten them at home that day. LPN-A stated "I'm sorry", but continued to go without eye protection for the rest of her shift. RN-A, the administrator nor the director of nursing (DON) redirected LPN-A to wear eye protection.	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 14 During interview on 10/27/21, at 11:09 a.m. the DON stated she was unaware any staff member used slip on side guards which were unapproved eye protection. All staff were expected to correctly wear approved eye protection to prevent the spread or transmission of COVID-19. During interview on 10/28/21, at 8:36 a.m. the administrator stated she was aware of staff not wearing eye protection correctly or wearing slip on side guards; however, was unaware of staff not wearing eye protection at all. The slip on side guards were unapproved eye protection, but the facility supplied all staff with goggles and all staff were expected to wear eye protection according to CDC guidance. The facility policy Care Center PPE dated 3/9/21, indicated the purpose of PPE was to protect staff or residents from possible exposure to different pathogens. Further, staff were directed to wear goggles or a face shield as added face/eye protection. Personal glasses were not a substitute for goggles. The Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes updated 9/10/21, healthcare personal (HCP) caring for residents with suspected or confirmed SARS-CoV-2 infection should use full PPE (gowns, gloves, eye protection ((goggles or a face shield that covers the front and sides of the face), and a NIOSH-approved N95 or equivalent or higher-level respirator). HAND HYGIENE:	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 15 During a dining observation on 10/25/21, at 5:35 p.m. residents were assisted to the dining room for their supper meals. The DON brought a cart around the room with a basin of warm soapy water, a stack of washcloths and a stack of hand towels. The DON applied gloves, placed a washcloth in the basin and wrung the washcloth out with both hands. From 5:42 p.m. until 5:46 p.m. the DON proceeded to approach each resident (R1, R2, R9, R10, R11, R13, and R122) to encourage them to wash their hands prior to their meal; however, the DON proceeded to go back into the basin of water with soiled gloves; contaminated water and moved on to the next resident, without changing water or completing self hand hygiene. After the last resident was assisted to wash their hands the DON removed her gloves, but did not perform hand hygiene. During interview on 10/25/21, at 5:53 p.m. the DON stated she was aware she had not changed gloves between residents when she assisted them to wash their hands prior to their meal. She attempted to touch the residents with her left hand only in order to leave her right hand clean; however, realized she went back into the water basin with both hands thus contaminated the water. "Ideally, I should have changed gloves after every resident" and the water was contaminated. At that time, the DON directed staff to use hand sanitizer wipes for all residents. A facility hand hygiene policy was requested but not received. EQUIPMENT: R4's quarterly minimum data set (MDS) dated 9/22/21, indicated R4 was totally dependent on staff for transfers and did not ambulate.	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 16 R4's medical record lacked evidence R4 had any signs or symptoms of COVID-19. R8's significant change MDS dated 8/31/21, indicated R8 required extensive assistance with transfers, was totally dependent on staff for locomotion and did not ambulate. R8's medical record lacked evidence R6 had any signs or symptoms of COVID-19. On 10/25/21, at 3:35 p.m. registered nurse (RN)-A and nursing assistant (NA)-B were transferring R4 into the wheelchair with a total mechanical lift. Upon exiting R4's room NA-B was not observed to disinfect the lift. NA-B stated she had not disinfected the lift with disinfecting wipes and did not know how often the lifts should be disinfected. During interview on 10/25/21, at 3:43 p.m. NA-C stated she did not disinfect the total mechanical lifts after each use and was uncertain how often the lifts were to be disinfected. - At 3:45 p.m. RN-A stated there was a sign attached to the total mechanical lift lifts which directed staff to disinfect it after each use. During observation on 10/26/21, at 1:02 p.m. trained medication aide (TMA)-A and NA-D transferred R6 from the wheelchair to a recliner using the total mechanical lift. Without disinfecting the lift, TMA-A and NA-D then wheeled the same lift into R4's room and transferred R4 from the bed to the wheelchair. Neither TMA-A or NA-D disinfected the total mechanical lift after transferring R6 or prior to transferring R4.	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 17 During interview on 10/26/21, at 1:12 p.m. activities aide (AA)-A stated the total mechanical lift lifts should be disinfected after every use. - At 1:18 p.m. TMA-A and NA-D stated they did not disinfect the total mechanical lift after transferring R6 and prior to transferring R4. Both TMA-A and NA-D stated they were supposed to disinfect the total mechanical lifts after every use. During interview on 10/28/21, at 11:43 a.m. the administrator stated the total mechanical lifts should be disinfected and staff were expected to disinfect the lifts between each use. Staff were aware of the policy which was in place since the start of the COVID-19 pandemic. The facilities Disinfecting and Disinfecting of Resident Equipment policy revised 3/9/21, identified reusable multiple-resident items as items that could be used multiple times for multiple residents and that could be a source of indirect transmission of pathogens. The policy further directed staff to clean and disinfect reusable multiple-resident items in accordance with current CDC recommendations in order to break the chain of infection. SUGGESTED METHOD OF CORRECTION: The DON, or designee could review and revise policies/procedures regarding infection surveillance, hand hygiene, equipment disinfection and prevention of outbreaks of infections. Then provide education to all staff. The DON or designee could develop and conduct audits to ensure compliance. The results of the audits could be brought forth to the facilty's Quality Assurance Performance Improvement (QAPI) committee for review.	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00470	A. BUILDING: _____ B. WING _____	C 10/28/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 18 TIME PERIOD FOR CORRECTION: Twenty (21) Days	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**11/02/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/02/2021. At the time of this survey, Riverview Hospital & Nursing Home was found not 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 and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/30/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**11/02/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Riverview Hospital & Nursing Home is a one-story building without a basement built in 1974 and determined to be of Type II(000) construction. In 2003, an addition to the south was added and is one-story without a basement and built of Type V(111) construction. The building is fully protected throughout by an automatic fire sprinkler system. It has a fire alarm system with smoke detection throughout the corridor, resident rooms, and spaces open to the corridor. The fire alarm is monitored for automatic fire department	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**11/02/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 notification. The nursing home is divided into two smoke compartments and is separated by a two-hour fire-rated wall from the hospital. Since the 1974 and 2003 construction types conform for a building of this height, it will be surveyed as one building of Type V(111) construction. The facility has a capacity of 24 beds and had a census of 22 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain an unobstructed exit discharge per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.2.7, and 7.7.1.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 11/02/2021 at 11:56, an observation revealed	K 211	On 11/30/2021, a new latch was ordered that is a single action style with no special tools or knowledge required that will allow egress through the gate to a public right of way, completing the proper path of egress as required by the Life Safety Code. The latch will be installed immediately upon arrival. In in the interim, the locking mechanism will be removed to allow free passage to the public right of way.	12/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**11/02/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 3 that the exit discharge through the courtyard led to a locked gate before the exit discharge terminated at the public way. An interview with the Director of Engineering Services confirmed the finding at the time of discovery.	K 211		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe	K 321		12/8/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**11/02/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 4 Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to enclose combustible storage in a hazardous storage room per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.2, and 19.3.2.1.5. This deficient finding could have a patterned effect on the residents within the facility: Findings include: On 11/02/2021 at 11:39 AM, an observation revealed combustible storage in a space open to the corridor across from Room 410. The storage included several large cardboard boxes of supplies and bed pads. An interview with the Director of Engineering Services confirmed the finding at the time of discovery.	K 321	On 11/2/2021, staff removed all combustible storage from the space and relocated the items to an approved storage location. Staff education was provided that this space is not an approved location for combustible storage and shall be kept free of these items at all times.	
K 914 SS=F	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	K 914		12/8/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**11/02/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 914	Continued From page 5 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 a review of the available documentation and staff interview, the facility failed to test hospital-grade electrical receptacles per NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.3.3.2 through 6.3.3.2.4, 6.3.4.1.1, and 6.3.4.1.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 11/02/2021 at 11:26 AM, a review of the available documentation revealed that there was no evidence provided for an initial outlet test at resident bed locations of the hospital-grade outlets. 2. On 11/02/2021 at 11:28 AM, a review of the available documentation revealed that there was no evidence that performance-based criteria had been established to test the hospital-grade outlets at resident bed locations. An interview with the Director of Engineering Services confirmed the finding at the time of discovery.	K 914	On 11/30/2021, the Director of Plant Services established a program for testing hospital grade outlets at the noted locations per the Life Safety Code and the Health Care Facilities code. The program will be executed by the Plant Services Staff at intervals defined in the program.	